Purcellville Pediatrics
Practicing Modern Medicine with a Hometown Touch

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New Patient Registration

Today's Date ____/____/____

Patient's Legal Name _____ Patient's SS# _____-_____-_____
Nickname (if any) _____ Patient's Date of Birth ____/____/____ Gender M/F
Home Address _____ City _____ Zip Code _____
Home Phone (____)_____-_____ Email (**no personal information will be sent**) _____

Names of siblings who are patients here
_____ _____
_____ _____

Mother/Legal Guardian's Name _____
Date of Birth ____/____/____ SS# _____-_____-_____
Home Address _____
Home Phone (____)_____-_____ Cell Phone (____)_____-_____
Occupation _____ Place of Employment _____
Work Phone (____)_____-_____ Ext _____

Father/Legal Guardian's Name _____
Date of Birth ____/____/____ SS# _____-_____-_____
Home Address _____
Home Phone (____)_____-_____ Cell Phone (____)_____-_____
Occupation _____ Place of Employment _____
Work Phone (____)_____-_____ Ext _____

Preferred Pharmacy Name and Telephone Number _____

If parents are divorced, who has legal custody of child?
_____

Who, if anyone other than the responsible party, has permission to be involved in your child's medical treatment, including bringing them in for visits?

_____ _____
Name and Relationship Name and Relationship

_____ _____
Name and Relationship Name and Relationship

I authorize the above listed individuals to be involved in my child's medical treatment.

_____
Parent or Legal Guardian

Insurance Information (Please give your insurance card(s) and Photo ID to the receptionist):

Primary Insurance Company's Name _____
Policy Holder's Name _____
Member ID# _____ Group # _____

Secondary Insurance Company's Name_____
Policy Holder's Name _____
Member ID# _____ Group # _____

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Purcellville Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Purcellville Pediatrics and I direct my insurance company to pay any and all such entitlements directly to Purcellville Pediatrics.

_____
Parent or Legal Guardian Responsible for Account

I authorize Purcellville Pediatrics to render medical care to my child. I understand that all co-pays and deductibles are to be paid at the time of service. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorney's fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Purcellville Pediatrics. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay in payment.

_____
Parent or Legal Guardian Responsible for Account

I have received the attached "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

_____
Parent or Legal Guardian Signature

I have received the attached "Office Policies and Procedures" and agree to its terms.

_____
Parent or Legal Guardian Signature

Whom may we thank for referring you?

_____