

# Pediatric Associates of Richmond, Inc.

## Child/Children Information:

Last Name                      First Name                      MI (Nickname)                      Date of Birth                      SS#                      Sex

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StreetAddress: \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_

**\*\*Check here if the information below applies to all children listed above. If not, please put child's initials next to appropriate responses.\*\***

<u>Race</u>	<u>Ethnicity</u>	<u>Language</u>
<input type="radio"/> Black or African American	<input type="radio"/> Hispanic or Latino	<input type="radio"/> English
<input type="radio"/> American Indian or Alaska Native	<input type="radio"/> Not Hispanic or Latino	<input type="radio"/> Other _____
<input type="radio"/> Asian	<input type="radio"/> Unknown	
<input type="radio"/> Hawaiian or Other Pacific Islander		
<input type="radio"/> Other Race		
<input type="radio"/> White		

## **Please provide phone number contact information to be used for updates and reminders**

Primary Contact Phone #: \_\_\_\_\_ 2nd Phone #: \_\_\_\_\_ 3rd Phone #: \_\_\_\_\_

Optional \*\* Email Address: \_\_\_\_\_

## Father's Information:

Last Name                      First Name                      MI                      Date of Birth                      SS#                      Marital Status

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StreetAddress: \_\_\_\_\_, City \_\_\_\_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_

## Mother's Information:

Last Name                      First Name                      MI                      Date of Birth                      SS#                      Marital Status

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StreetAddress: \_\_\_\_\_, City \_\_\_\_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_

## Emergency Contact (Other than Parent) Information:

Last Name                      First Name                      MI                      Address                      Phone #                      Relationship to child

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**Authorized to seek Treatment:** - In addition to the emergency contact listed above the following individuals may bring my child/children to Pediatric Associates of Richmond, Inc. for treatment:

Last Name	First Name	MI	Address (optional)	Phone #	Relationship to child

**Insurance Information:**

Primary Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_

Our **Notice of Privacy Practices** provides information about how we may use and disclose PHI (Protected Health Information) about you, your child/children. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

I, \_\_\_\_\_ (Please print parent/guardian name) have received a copy of the Pediatric Associates of Richmond's Notice of Privacy Practices.

Fees incurred are payable when services are rendered and are the sole responsibility of the parent and / or guardian. I agree that in the event that my account must be turned over to an attorney for collection, that I will be responsible for attorney fees, court costs and interest. I hereby authorize my insurance benefits be assigned to Pediatric Associates of Richmond, Inc. and authorized Pediatric Associates of Richmond, Inc. to furnish all information regarding my child's medical history, diagnosis and treatment to my insurance company, and authorize Pediatric Associates of Richmond, Inc. to furnish such medical information as Pediatric Associates of Richmond, Inc. determines necessary during the course of my child's treatment to any individual above authorized to consent to my child's treatment and to any other person who presents with my child for treatment in my absence.

I certify the above information is correct.

\_\_\_\_\_  
Parent / Guardian Signature                      Please Print Name                      Date: