PATIENT REGISTRATION RECORD

PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

OFFICIAL USE ONLY
DATE

INITIAL

FAMILY HISTORY NUMBER

Patient Last Name _____ Primary Dr. at Pediatric Associates _____

First Name _____ Middle Name _____ Patient's Date of Birth _____

Nickname/Name patient is called *(if different from first name)* _____ Patient's Sex *(circle one)* Male Female

Mailing Address _____ Patient's SS# _____

City _____ Street Address is the same as mailing address ❍

State _____ Zip _____ *if different*, Address _____

Please check preferred number to call (❍) City _____ State _____ Zip _____

Home Phone ❍ _____ Patient cell ❍ _____ Child lives with _____

Mother's name _____ Mother's work ❍ _____ Mother's cell ❍ _____ email address _____

Father's name _____ Father's work ❍ _____ Father's cell ❍ _____ email address _____

Other important phone #s (stepparent, grandparent, other...) _____

Name _____ relationship _____ phone # _____ email address _____

Father's Occupation _____ Mother's Occupation _____

Responsible Party (person who is responsible for medical bills) Emergency Contact (in addition to parent)

Name _____ Name _____

Date of Birth _____ Sex _____ Relationship _____ Phone # _____

Insurance Information _____
Medical Insurance Company Policy # Group #

_____
Subscriber (Policy Holder) Policy Holder date of birth

Primary Pharmacy _____

MEANINGFUL USE **Meaningful use is a government mandate for healthcare providers to improve health care quality, safety, and efficiency through the promotion of health information technology.

Please check one:
**Race: ___ American Indian/Alaska Native ___ Asian ___ Black/African American
___ Native Hawaiian or Other Pacific Islander ___ Hispanic ___ White ___ Decline to Report

Please check one:
**Ethnicity: ___ Hispanic or Latin ___ Not Hispanic or Latin ___ Decline to Report

Please check one:
**Language: ___ English ___ Spanish ___ Russian ___ Indian (includes Hindi & Tamil) ___ Other

Consent to Medical Care

I hereby request and authorize the providers of Pediatric Associates of Charlottesville to perform any medical diagnostic procedures, medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the patient's condition and/or provide well child care. Additionally, I acknowledge that I am hereby informed in accordance with the Code of Virginia Section 32.1, that if the provisions of health care services exposes any health care worker to the patient's body fluids in a manner that may transmit immunodeficiency virus or HIV or Hepatitis, that the patient shall be deemed to have consented to testing for the infections and to release the test results to the person(s) exposed.

_____
Name Date Relationship to Patient

Consent to the Treatment of Minors

I authorize the providers at Pediatric Associates of Charlottesville to provide medical care to my child(ren) in my absence when accompanied by the following persons:

_____
Name Relationship to patient

_____
Name Relationship to patient

Please Read, Initial and Sign Back of Form

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FINANCIAL POLICY

I accept full financial responsibility for all medical services rendered to my children. I agree to pay all insurance co-payments, deductibles, and co-insurance under the terms of their health insurance plan.

I accept full financial responsibility for all medical services rendered.

Co-payments are due on the date services are rendered. A $5.00 Billing fee will be added to your account if a co-pay is not made at the time of service.

I understand that in the event that I fail to make such payments or default on my payments that the doctor-patient relationship may be terminated. In the event of default of my financial obligations, I agree to pay all relevant costs associated with collection actions taken by Pediatric Associates.

I accept full responsibility for assigning Pediatric Associates as the PCP on my child(ren)'s health insurance.

Patients without health insurance will be required to pay a $20.00 fee at time of service. Any additional charges will be billed to you.

I authorize that all insurance benefits due and payable for medical services rendered be paid directly to Pediatric Associates of Charlottesville.

I authorize Pediatric Associates to disclose any parts of my child(ren)'s medical record to my child's insurance company so that an insurance claim may be processed, or as may be required by the contract with the insurance company.

I am responsible for charges accrued by my child(ren) under the age of eighteen whether unaccompanied or in the presence of a parent or caregiver.

I understand that Pediatric Associates is HIPAA compliant and will protect my child(ren)'s personal information.

The undersigned certifies that he/she has provided correct information in this Patient Registration Record and understands that any false statements or concealment of material may in fact be prosecuted under applicable federal and state laws.

Signature | Date | Relationship to patient

Print Name

Pediatric Associates of Charlottesville conducts clinical research trials in conjunction with Pediatric Research of Charlottesville. Clinical trials study many different aspects of health. They may involve studying vaccines, infectious diseases, migraines, asthma and ear treatments.

May we have permission for Pediatric Research of Charlottesville to contact you if your child appears to be eligible to participate in a research study?

- ❑ Y**es**, feel free to contact me if there is an appropriate study that my child may be eligible to participate in.
- ❑ **No**, do not contact me for any clinical research study.