Primary Doctor at Pediatric Associates ____________________

Patient Name Nickname Date of Birth Gender (M,F,I, TM, TF,O)

Parent 1/Legal Guardian Information: This is the person that will primarily receive emails, calls, and texts from Pediatric Associates.
❏Mother, ❏Father, ❏Stepmother, ❏Stepfather, ❏Grandmother, ❏Grandfather, ❏Foster Parent, ❏Other____________________

Name Date of Birth Social Security Number

Street Address City State Zip Code

Cell Phone Work Phone Home Phone

Email Address Occupation Employer

Best Contact Number: ❏Home ❏Work ❏Cell (❏OK to send text messages)

Parent 2/Legal Guardian Information:
❏Mother, ❏Father, ❏Stepmother, ❏Stepfather, ❏Grandmother, ❏Grandfather, ❏Foster Parent, ❏Other____________________

Name Date of Birth Social Security Number

Street Address or ❏ same as Parent 1 City State Zip Code

Cell Phone Work Phone Home Phone

Email Address Occupation Employer

Best Contact Number: ❏Home ❏Work ❏Cell (❏OK to send text messages)

Custody Information (if applicable):

❏ Joint legal and physical for both parents above ❏ Joint legal with physical retained by: ❏Parent 1, or ❏ Parent 2 ❏ No formal custody arrangement ❏ Sole legal and physical retained by ❏Parent 1, or ❏ Parent 2	DSS: ❏Alb, ❏Charl, ❏Fluvanna, ❏Greene, ❏Louisa, ❏Nelson, ❏Madison, ❏Orange, ❏Buckingham, ❏Other_____________ ❏ Medical Records Access Restricted (Legal Documentation required)

Insurance Information: ❏Private, ❏Medicaid, ❏Self Pay
Responsible Party (responsible for the bill/insurance): ❏ Same as Parent 1, ❏Same as Parent 2, ❏DSS, ❏Other (if other, enter info below)

Name Date of Birth Relationship to Patient

Street Address City State Zip Code

EMERGENCY CONTACTS: Add at least one person, preferably not a parent listed above

Name Relationship Phone number

LIST OTHER CHILDREN <18 yo THAT ARE PATIENTS WITH THIS SAME REGISTRATION INFO ABOVE (include name, gender, dob):

____

____

____

PREFERRED PHARMACY____

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. I understand that co-payments are due on the date services are rendered. 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 insurance. I understand that patients without health insurance will be required to pay a $50.00 fee at time of service, and any additional charges will be billed to me. I authorize that all insurance benefits due and payable for medical services rendered be paid directly to Pediatric Associates. I authorize Pediatric Associates to disclose any parts of my child(ren)'s medical record to my child(ren)'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. I certify that I have provided the correct information on this Patient Registration and understand that I may be prosecuted for any false statements or concealment of material under applicable federal and state laws.

Permission for Others to Bring Patient to the Office
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 (ex. Grandparents, nanny, friend, stepparent, adolescent who can drive themselves):

______________________________________ ______________________________________
Name Relationship to patient Name Relationship to patient

Consent to Medical Care
I accept the conditions of the financial policy printed on this form. 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 services expose any health care worker to the patient's body fluids in a manner that may transmit 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.

❑Parent 1, or ❑Parent 2

____
Signature Date

Language: ❑English, ❑Spanish, ❑Arabic, ❑Portuguese, ❑French, ❑Italian, ❑Russian, ❑Hindi, ❑Tamil, ❑Other_______________________

Race: ❑Decline to answer, ❑American Indian/Alaska Native, ❑Asian, ❑Black/African American, ❑Native Hawaiian/Other Pacific Islander ❑Hispanic, ❑White, ❑Mixed, ❑Other_______________________

Ethnicity: ❑Decline to answer, ❑Hispanic or Latinx, ❑Not Hispanic or Latinx, ❑Mixed, ❑Other ______________________

Pediatric Associates of Charlottesville conducts clinical research trials in conjunction with **Pediatric Research of Charlottesville**
May we have permission for Pediatric Research of Charlottesville to contact you to participate in a research study?

❑**Yes**, feel free to contact me if there is an appropriate study for which my child may be eligible

❑**No,** do not contact me for any clinical research study