PATIENT REGISTRATION RECORD
PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

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Primary Dr at Pediatric Associates

Patient Name | Date of Birth | Gender (M,F,I, TM, TF,O) | Patient's SSN

_______________________ ____

Patient's Cell Phone (if applicable) | Other siblings and their date(s) of birth

Parent 1/Legal Guardian Information:
○ Mother, ○ Father, ○ Stepmother, ○ Stepfather, ○ Grandmother, ○ Grandfather, ○ Foster Parent, ○ Other_________________________

Name | Date of Birth | Social Security Number

Street Address | City | State | Zip Code

Cell Phone | Home Phone | Work Phone

Email Address | Occupation | Employer

Other Persons Living at this Address
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 (if different from Parent 1) | City | State | Zip Code

Cell Phone | Home Phone | Work Phone

Email Address | Occupation | Employer

Other Persons Living at this Address
Best Contact Number: ○ Home ○ Work ○ Cell (○ OK to send text messages)

Custody Information (if applicable):
○ Joint legal and physical ○ Joint legal with physical retained by:______________________________ ○ No formal custody arrangement
○ Sole legal and physical retained by:___________________________ ○ **Medical Records Access Restricted** (Legal Documentation required)

Responsible Party (who is responsible for the bill/insurance): ○ Same as Parent 1, ○ Same as Parent 2

Name | Date of Birth | Relationship to Patient

Street Address | City | State | Zip Code

Insurance Information ____
Medical Insurance Company | Policy # | Group #

Subscriber (Policy Holder) | Policy Holder Date of Birth

Other important phone numbers: 1.____
Name | Relationship | Phone number

2.____________________________________ 3.____________________________________
Name | Relationship | Phone number | Name | Relationship | Phone number

Please use this space to list other important persons that live in your child's house or other addresses at which your child resides part time

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PATIENT REGISTRATION RECORD

PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

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 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.

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Name Date Relationship to Patient

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

_______________________________________ _______________________________________

Name Relationship to patient Name Relationship to patient

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 in each group.

Race: ____American Indian/Alaska Native ____Asian ____Black/African American ____Native Hawaiian/Other Pacific Islander ____Hispanic ____White ____Decline to Report

Ethnicity: ____Hispanic or Latin ____Not Hispanic or Latin ____Decline to Report

Language: ____English ____Spanish ____Russian ____Indian (includes Hindi &Tamil) ____Other_______________________

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.

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.

Patients without health insurance will be required to pay a $50.00 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.

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.

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 by prosecuted under applicable federal and state laws.

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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/or ear treatments.

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

_____ **Yes**, 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