VALLEY PEDIATRIC ASSOCIATES, LLC

YOUR CHILD

NAME: ______________________________
Last, First, MI

Birth Date: ______________ Sex: ☐M ☐F

Gender Identity: ______________________

Social Security #: ______________________

Primary Language(s) spoken at home: __________

Mailing Address: ______________________

City, State, Zip: ______________________

Phone PRIMARY: ______________________

Phone CELL: ______________________

If Patient is over 15 years old:

PATIENT CELL: ______________________

PATIENT E-mail: ____________@__________

SIBLINGS

NAME	DOB	M F
		☐ ☐
		☐ ☐
		☐ ☐
		☐ ☐
		☐ ☐

Child's regular Doctor: ______________________

Ethnicity: Hispanic/Latino: ☐Yes ☐No ☐Declined

Race (may choose more than 1):

☐American Indian ☐Asian ☐Black

☐Hawaiian/Pac Islander ☐White ☐Declined

[These questions are required under Meaningful Use rules]

PARENT 1: ☐**Mother** ☐**Step-parent** ☐**Other**

NAME: ______________________________
Last, First, MI

Sex: ☐ M ☐ F Birth Date: ______________

Language: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone HOME: ______________________

Phone WORK: ______________________

Phone CELL: ______________________

E-mail: ____________@__________

Social Security #: ______________________

Employer: ______________________

Occupation: ______________________

Lives with patient: ☐ Yes ☐No

Relation to Patient: ______________________

How would you prefer to be contacted for:

Recall (e.g. due for checkup or vaccine) **:**
☐ Text to cell ☐ E-mail

General Notices (e.g. office announcements) **:**
☐ Text to cell ☐ E-mail

Patient Portal (notice of new portal message) **:**
☐ Text to cell ☐ E-mail

Appointment Reminders :
☐ Home Phone ☐ Cell Phone ☐ Text to cell ☐ E-mail

PARENT 2: ☐**Father** ☐**Step-parent** ☐**Other**

NAME: ______________________________
Last, First, MI

Sex: ☐ M ☐ F Birth Date: ______________

Language: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone HOME: ______________________

Phone WORK: ______________________

Phone CELL: ______________________

E-mail: ____________@__________

Social Security #: ______________________

Employer: ______________________

Occupation: ______________________

Lives with patient: ☐ Yes ☐No

Relation to Patient: ______________________

How would you prefer to be contacted for:

Recall (e.g. due for checkup or vaccine) **:**
☐ Text to cell ☐ E-mail

General Notices (e.g. office announcements) **:**
☐ Text to cell ☐ E-mail

Patient Portal (notice of new portal message) **:**
☐ Text to cell ☐ E-mail

Appointment Reminders :
☐ Home Phone ☐ Cell Phone ☐ Text to cell ☐ E-mail

____
Signature

______________________________________ ____________________
Printed Name Date

PRIMARY INSURANCE:

Policy Holder Name: ______________________
(Last, First, MI)

Social Security #: ______________________

Sex: ☐ M ☐ F Birth Date: ____________

Patient Relationship to Subscriber: ____________

Insurance Company: ______________________

ID#: ____________ Group #: ____________

Group Name: ____________

SECONDARY INSURANCE:

Policy Holder Name: ______________________
(Last, First, MI)

Social Security #: ______________________

Sex: ☐ M ☐ F Birth Date: ____________

Patient Relationship to Subscriber: ____________

Insurance Company: ______________________

ID#: ____________ Group #: ____________

Group Name: ____________

BILLING STATEMENTS SENT TO:
(If different from policy holder)

NAME: ______________________
(Last, First, MI)

Sex: ☐ M ☐ F Birth Date: ____________

Social Security #: ______________________

Mailing Address: ______________________

City, State, Zip: ______________________

E-mail: ______________________

Phone HOME: ______________________

Phone CELL: ______________________

Phone WORK: ______________________

Lives with patient: ☐ Yes ☐ No

EMERGENCY CONTACTS (other than parents):

1: ______________________ Relationship: ____________ Phone: ____________

2: ______________________ Relationship: ____________ Phone: ____________

PERMISSION for ALTERNATE CARE GIVERS (for **sick** visits; a parent is required at checkups):
I give permission to the following people to bring our children to the office:

1: ______________________ Relationship: ____________ Phone: ____________

2: ______________________ Relationship: ____________ Phone: ____________

PRIVACY CONSTRAINTS – Any restrictions on who can have access to child's medical records (Check one):

☐ No restrictions (OK to leave message/E-mail)

☐ Restrictions (e.g. only mother or only phone, no email): ______________________

****

If parents are divorced or separated, please fill out this section:

Who has custody? ______________________

Are there any legal restrictions that would prohibit the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐Yes ☐No

If yes, please explain. You **MUST** provide a copy of **any legal paperwork** that supports this restriction.

____

****

PLEASE SIGN BELOW:

____
Signature

______________________ ____________
Printed Name Date