VALLEY PEDIATRIC ASSOCIATES, LLC

YOUR CHILD

NAME: _____
(Last, First, MI)

Birth Date: ___/___/_____ Sex: F M

Social Security #: _____

Mailing Address: _____

City, State, Zip: _____

Phone (Home, cell, other): _____

Phone (Home, cell, other): _____

Email: _____@_____

Child's regular Doctor: _____

PARENT 1: ☐**Mother** ☐**Stepparent** ☐**Other**

NAME: _____
(Last, First, MI)

Social Security #: _____

Sex: F M Birth Date: ___/___/_____

Mailing Address: _____

City, State, Zip: _____

Email(home): _____@_____

Email(work): _____@_____

Employer: _____

Occupation: _____

Phone (Home, work, cell, other): _____

Phone (Home, work, cell, other): _____

Phone (Home, work, cell, FAX, other): _____

Lives with patient (circle one): Yes No

Relation to Patient: _____

How would you prefer to be contacted for (CIRCLE ONE):

Medical Issues (e.g. test results) **(CIRCLE ONE):**
Home phone Work Phone Cell Phone Text to cell
Home E-mail Work email

Appointment Reminders (CIRCLE ONE):
Home phone Work Phone Text to cell
Home E-mail Work email

Recall (e.g. due for checkup or vaccine) **(CIRCLE ONE):**
Text to cell Home E-mail Work email

Billing Statements (CIRCLE ONE):
Mail Home E-mail Work email

General Notices (e.g. office announcements) **(CIRCLE ONE):**
Text to cell Home E-mail Work email

Patient Portal (notice of new portal message) **(CIRCLE ONE):**
Text to cell Home email Work mail

SIBLINGS Name DOB Sex

		M F
		M F
		M F
		M F
		M F

Primary Language spoken at home: _____

Ethnicity: Hispanic: Yes No

Race: Amer. Indian Asian Black Hawaiian White
[Why are we asking this? See attached]

PARENT 2: ☐**Father** ☐**Stepparent** ☐**Other**

NAME: _____
(Last, First, MI)

Social Security #: _____

Sex: F M Birth Date: ___/___/_____

Mailing Address: _____

City, State, Zip: _____

Email(home): _____@_____

Email(work): _____@_____

Employer: _____

Occupation: _____

Phone (Home, work, cell, other): _____

Phone (Home, work, cell, other): _____

Phone (Home, work, cell, FAX, other): _____

Lives with patient (circle one): Yes No

Relation to Patient: _____

How would you prefer to be contacted for (CIRCLE ONE):

Medical Issues (e.g. test results) **(CIRCLE ONE):**
Home phone Work Phone Cell Phone Text to cell
Home E-mail Work email

Appointment Reminders (CIRCLE ONE):
Home phone Work Phone text to cell
Home E-mail Work email

Recall (e.g. due for checkup or vaccine) **(CIRCLE ONE):**
Text to cell Home E-mail Work email

Billing Statements (CIRCLE ONE):
Mail Home E-mail Work email

General Notices (e.g. office announcements) **(CIRCLE ONE):**
Text to cell Home E-mail Work email

Patient Portal (notice of new portal message) **(CIRCLE ONE):**
Text to cell Home email Work mail

PRIMARY INSURANCE:

Policy Holder Name: _____
(Last, First, MI)
Social Security #: _____
Sex: F M Birth Date: ____/____/_____
Insurance Company: _____
ID#: _____
Group #: _____
Group Name: _____

SECONDARY INSURANCE:

Policy Holder Name: _____
(Last, First, MI)
Social Security #: _____
Sex: F M Birth Date: ____/____/_____
Insurance Company: _____
ID#: _____
Group #: _____
Group Name: _____

BILLING STATEMENTS SENT TO:
(If different from above)

NAME: _____
(Last, First, MI)
Sex: F M Birth Date: ____/____/_____
Relation to Patient: _____
Lives with patient (circle one): Yes No
Social Security #: _____
Mailing Address: _____
City, State, Zip: _____
Phone (Home, cell, other): _____
Phone (Home, cell, other): _____

Emergency Contact (other than parents):

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/email)
_____ Restrictions (Person-to-person w/ patient or guardian only).
_____ Restrictions: _____

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

Who has custody? _____
Are there any legal restriction that would restrict 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 and provide a copy of any legal paperwork that supports this restriction.

_____

_____ ____/____/_____
Signature Date