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): ______________________________

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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.

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PLEASE SIGN BELOW:

____
Signature

____ ______________________
Printed Name Date