VALLEY PEDIATRIC ASSOCIATES, LLC YOUR CHILD

Last, First, MI Gender Identity; Social Security #: Child's regular Doctor: Child's regu	Name:			NAME	DOB M F	
Gender Identity: Social Security #: Primary Language(s) spoken at home: General Notices General		First,	MI			
Gender Identity: Social Security #: Primary Language(s) spoken at home: General Notices General	Birth Date:	Sex:	\Box M \Box F			
Social Security #: Primary Language(s) spoken at home: Mailing Address: Child's regular Doctor: Ethnicity: Hispanic/Latino:						
Primary Language(s) spoken at home: Mailing Address: City, State, Zip: Phone PRIMARY: Phone PRIMARY: Phone PRIMARY: Phone PRIMARY: Phone CELL: Race (may choose more than 1): Hawaiian/Pac Islander White Declined These questions are required under Meaningful Use rules PATIENT CELL: 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: Address: City, State, Zip: City, State, Zip: Phone HOME: Phone WORK: Phone CELL: E-mail: @ Social Security #: E-mail: @ Social Secur						
Mailing Address: City, State, Zip: Phone PRIMARY: Phone CELL: PATIENT CELL: PATIENT E-mail:						
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City, State, Zip: Phone PRIMARY: Phone CELL:	Mailing Address:			Child's regular Doctor:		
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PATIENT CELL: PATIENT CELL: PATIENT E-mail: PARENT 1:	Phone CELL:					
PARENT 1:	If Patient is over 15 ye	ars old:		☐American Indian	□Asian □Black	
PARENT 1:	PATIENT CELL:			□Hawaiian/Pac Islander	□White □Declined	
NAME: Last, First, MI Sex: M F Birth Date: Sex: M F Birth Date: Language: Language: Address: City, State, Zip: City, State, Zip: Phone HOME: Phone HOME: Phone WORK: Phone WORK: Phone WORK: Phone CELL: E-mail: @ E-mail: @ Social Security #: Social Security #: Employer: Occupation: Lives with patient: Yes No Relation to Patient: 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 Appointment Reminders: Home Phone Cell Phone Text to cell E-mail Signature Sex: M F Birth Date: Last, First, MI F Birth Date: Lasuage: Address: City, State, Zip: More Patient F Birth Date: Lasuage: Address: Lasuage: Address: Lasuage: Address: Lasuage: Address: Address: City, State, Zip: Permit Date (Institute of new portal message): Text to cell E-mail Description: Lives with patient: Lives with patient: Lower Britanian Appointment Reminders: Home Phone Cell Phone Text to cell E-mail	PATIENT E-mail:	@	0	•		
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Relation to Patient:				Employer:		
Relation to Patient:	Occupation:			Occupation:		
How would you prefer to be contacted for: Recall (e.g. due for checkup or vaccine):	Lives with patient:	□ Yes □	No	Lives with patient:	□ Yes □No	
Recall (e.g. due for checkup or vaccine): Text to cell E-mail E-mail E-mail	Relation to Patient:			Relation to Patient:		
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Printed Name Date	Signature					
	Printed Name					

SIBLINGS

PRIMARY INSURANCE: **BILLING STATEMENTS SENT TO:** (If different from policy holder) Policy Holder Name: ___ First. NAME: Social Security #: _____ First. (Last, □ M □ F Birth Date: _____ Sex: □ M □ F Birth Date: Patient Relationship to Subscriber: Social Security #: Mailing Address: Insurance Company: _____ ID#: _____ Group #: ____ City, State, Zip: Group Name: E-mail: Phone HOME: **SECONDARY INSURANCE:** Phone CELL: Policy Holder Name: Phone WORK: First, MI) Lives with patient: \square Yes \square No Social Security #: ☐ M ☐ F Birth Date: Sex: Patient Relationship to Subscriber: Insurance Company: _____ ID#: _____ Group #: _____ Group Name: _____ **EMERGENCY CONTACTS (other than parents):** 1: ______ Phone: ______ 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: ______ 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? \Box Yes \Box 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