Annual Patient Registration and Information

Please complete all information.

Patient name | Date of Birth | Sex (M or F) | Patient's Social Security Number

Parent / Legal Guardian Information

☐ Mother ☐ Father ☐ Stepmother* ☐ Stepfather* ☐ Foster Mother ☐ Foster Father ☐ Other:_____

Name | Maiden Name | Date of Birth | Social Security Number

Street address and P.O. Box, if applicable | City | State | Zip code

( ) - @

Home Phone | Email Address

( ) - ( ) -

Mobile Phone | Work Phone

Employer

Employer Address

Best Contact Number

☐ Home ☐ Work ☐ Mobile (☐ OK to Send Text Messages)

Custody Information (Complete when are separated)

☐ Joint legal and physical

☐ Joint legal with physical custody retained by:

☐ Mother ☐ Father

☐ Sole legal and physical custody

☐ No formal custody arrangements

☐ Lives independently

Has Medical Records Access been restricted?

☐ Yes (Legal Documentation Required

Parent / Legal Guardian Information / Other

☐ Mother ☐ Father ☐ Stepmother* ☐ Stepfather* ☐ Foster Mother ☐ Foster Father ☐ Other:_____

Name | Maiden Name | Date of Birth | Social Security Number

Street address and P.O. Box, if applicable | City | State | Zip code

( ) - @

Home Phone | Email Address

( ) - ( ) -

Mobile Phone | Work Phone

Employer

Employer Address

* Step-parents need a permission to treat

Best Contact Number

☐ Home ☐ Work ☐ Mobile (☐ OK to Send Text Messages)

For our New Patients

Which Office is More Convenient?

☐ Charlottesville

☐ Crozet

☐ No Preference

How Did You Hear About Us?

☐ Internet Search

☐ Advertisement

Where? _____

☐ Referring Physician

☐ Insurance

☐ Current or Former Patient

Can we thank them? _____

Phone or Email: _____

☐ Other _____

Are You?

☐ New to the Charlottesville Area

☐ New To Piedmont Pediatrics

☐ Returning to Piedmont Pediatrics

Please complete and sign back of form. Thank you!

Annual Patient Registration and Information

Please complete all information.

Patient name | Date of Birth | Sex (M or F) | Patient's Social Security Number

Emergency Contact (Not Parent or Guardian)

1. Name | Relationship to Patient

Street address and P.O. Box, if applicable | City | State | Zip code

( ) - | ( ) - | ( ) -

Home Phone | Work Phone | Mobile Phone ☐ OK to Send Text Messages

2. Name | Relationship to Patient

Street address and P.O. Box, if applicable | City | State | Zip code

( ) - | ( ) - | ( ) -

Home Phone | Work Phone | Mobile Phone ☐ OK to Send Text Messages

Insurance Information (Not required if Insurance card is presented today)

☐ Commercial Plan ☐ Medicaid Plan ☐ No Insurance

Insurance Carrier | Subscriber Name | Subscriber Date of Birth | ☐ Commercial Plan

Relationship to Patient | ☐ Medicaid Plan

ID / Policy Number | Group Number | Phone Number (On Back of Card)

Permission to Treat Without Parent/Guardian Accompanying Child (Please use our full permission to treat form if limitations are needed)

Piedmont Pediatrics must receive permission from a child's parent or legal guardian before providing treatment for an injury or illness that is non-life threatening. If this information is not on file with us or presented by the adult accompanying your child (baby-sitter, relative, friend), Piedmont Pediatrics will contact the child's parent or legal guardian before he or she is seen by the physician. If permission is not received, care may not be provided.

I give consent by proxy to the individuals listed below, as my proxy decision maker(s) for consenting to non-urgent medical care for my child(ren) listed above. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. I understand that protected patient health information may be shared with the proxy(s) to whom the right to consent has been delegated to facilitate informed decision making.

Name | ( ) - Phone Number | Relationship to Patient(s)

Name | ( ) - Phone Number | Relationship to Patient(s)

I certify that I am the parent/legal guardian of this child and that all information provided on this registration form is true and accurate. I give consent to Piedmont Pediatrics, its medical staff and other providers involved in my care to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations.

X_____

Guarantor (Parent/Guardian) **Date** Relationship to Patient