WEST END PEDIATRICS, P.C.

Website
rev 04-2012

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Using LEGAL NAME, please list all children currently seen in our office. (Patients 0 through 17 yrs)

LAST NAME	FIRST	MIDDLE	(Nickname)	Date of Birth	Sex	Allergies?/Specify
1.						
2.						
3.						
4.						

Address Where Children Reside: Street/PO Box ______________________ Home Ph ______________

City/State/Zip Code ______________________________

Preferred Pharmacy / Location: ______________________ Phone ______________

______________________________ Referred to practice by ______________
EMERGENCY Contact Other Than Parent (Name, Relationship To Child, Phone Number) (optional)

MOM'S INFO
Name ______________________

Address ______________________

City/State/ Zip ______________________

Date of Birth ______________

e-mail (optional) ______________

Home Phone __________ Work Phone __________
Cell Phone __________
Employer ______________________

DAD'S INFO
Name ______________________

Address ______________________

City/State/Zip ______________________

Date of Birth ______________

e-mail (optional) ______________

Home Phone __________ Work Phone __________
Cell Phone __________
Employer ______________________

BILLING INFORMATION
Who is responsible for charges not covered by insurance? ______________________
Address where statement should be sent ______________________
Home Phone ______________ Work Phone ______________
Relationship to Child/Children ______________________

INSURANCE INFORMATION

Primary Insurance: ______________________

Policyholder ______________
Policyholder Address ______________________
____
Relationship To Patient__________ Copay Amt $ ______
Employer ______________________
Ins ID # ______________ Group # ______
Policyholder's Date of Birth ______________

Secondary Insurance: ______________________

Policyholder ______________
Policyholder Address ______________________
____
Relationship To Patient __________ Copay Amt $______
Employer ______________________
Ins ID# ______________ Group # ______
Policyholder's Date of Birth ______________

I hereby authorize the above named physicians to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named physicians of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event my account must be turned over to an attorney for collection, that I will be responsible for attorney's fees, court cost and interest. ***PLEASE SIGN BELOW & CONTINUE ON BACK…***

X______________________ X______________________ X______________
Signature of Parent or Legal Representative Relationship to Patient(s) Date

WEST END PEDIATRICS, P.C.
9606 Patterson Avenue
Richmond, VA 23229

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DEEMED CONSENT FORM
REQUIRED

I understand, that the laws of Virginia require that if my physician or any person employed by my physician(s) is directly exposed to my child's body fluids that may transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses according to the current guidelines for the Center for Disease Control, that I consent to have my child tested for infection with HIV or Hepatitis B or C viruses. I further understand that by law I consent to the release of these test results to the person(s) who is exposed to my child's body fluids. (See reverse side for names of children seen in our office)

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DISCLOSURES TO FAMILY / FRIENDS
(not including daycare, schools, camps)

Please list all persons (ex. Grandparent, babysitter, friend) who may receive health information regarding my child(ren) (ex. scheduling, medical advice, treatment, prescriptions, medical forms, medical records and billing information.) These individuals may be asked to present identification. If someone other than those you list below contacts us regarding your child, we will contact you for permission to advise or treat. In the event of an emergency, we will treat and make every possible attempt to contact you.

NAME	RELATIONSHIP	PHONE #	If any restrictions, list below:

This authorization will remain in effect until further written notice by patient / legal representative to:

Privacy Officer, West End Pediatrics, P.C., 9606 Patterson Avenue, Richmond, VA 23229

I understand that once information is released by West End Pediatrics, P.C., the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

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WRITTEN ACKNOWLEDGEMENT: Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. I have received a copy of the West End Pediatrics, PC's Notice of Privacy Practices. I have had an opportunity to read the notice and understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices.

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I certify the above information is correct:

X____X___________ ______________________________
Signature of Parent or Legal Representative Date (office use – initial) Date

X____
Please Print Name