GLEN ALLEN PEDIATRICS
PATIENT REGISTRATION FORM
Please Print Clearly and Complete All Blanks

CHILD'S FULL LEGAL NAME
1. ______________________ DOB ______________ M/F
2. ______________________ DOB ______________ M/F
3. ______________________ DOB ______________ M/F
4. ______________________ DOB ______________ M/F

CHILD'S HOME ADDRESS ______________________
City ____________ State ________ Zip ________

Preferred Method of Appt. Reminder: Call Home # ____________ Call/Text Cell # ____________

FATHER'S FULL NAME: ______________________ DOB ____________
Home Address ______________________ Apt.. No. ____________
City ____________ State ________ Zip ________ SSN# _______-_______-_______
Home Phone ____________ Cell Phone ____________ Work Phone ____________
E-Mail Address ______________________
Preferred method of contact: (circle one) HOME / CELL / WORK

MOTHER'S FULL NAME ______________________ DOB ____________
Home Address ______________________ Apt. No. ____________
City ____________ State ________ Zip ________ SSN# _______-_______-_______
Home Phone ____________ Cell Phone ____________ Work Phone ____________
E-Mail Address ______________________
Preferred method of contact: (circle one) HOME / CELL / WORK

PRIMARY INSURANCE COMPANY ______________________
Policy or ID# ______________________ Group # ____________
Subscriber/Policyholder Name ______________________ DOB ____________
SECONDARY INSURANCE: ______________________
Policy or ID# ______________________ Group # ____________
Subscriber/Policyholder Name ______________________ DOB ____________
Address/Phone (if different than above) ______________________

IN EMERGENCY NOTIFY: (other than parents)
Name ______________________ Home Phone ____________
Relationship to Patient ______________________ Cell Phone ____________

Referred to practice by ______________________

The patient/guarantor is responsible for knowing the specifics of his/her insurance plan and following its procedures. We strongly advise checking with your insurance carrier prior to visiting a Specialty Doctor, obtaining x-rays, hospital admissions and any other outside services. The patient/guarantor is responsible for communicating any of the above special needs to office staff and is ultimately responsible for payment for any services rendered.
Please sign below signifying that you have read and understand the above statement and this office has permission to submit insurance claims on your behalf and has permission to release any information, including medical, to the above carrier. I agree that if I an unable to furnish my insurance card or proof of insurance at the time of service, I will be personally responsible for the balance in full until such information is provided. I understand that I am financially responsible for charges not covered by this authorization as well as any balance not paid by insurance. If my account is turned over to any attorney for collection, I will be responsible for attorney fees in the amount of thirty-five percent (35%) of the total debt plus court costs. Any outstanding balances are subject to service charges.

Signature of parent/guardian/patient over age 18 ______________________ Date ____________
Revised 4/12