

# WEST END PEDIATRICS, P.C.

WEBSITE

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List **ALL** Children Below (Please Print and use **LEGAL** names)

	<u>LAST NAME</u>	<u>FIRST</u>	<u>MIDDLE</u>	<u>(Nickname)</u>	<u>Date of Birth</u>	<u>Sex</u>	<u>Allergies?/Specify</u>
1.	_____						
2.	_____						
3.	_____						
4.	_____						
Address Where Children Reside:		Street/PO Box _____					
		City/State/Zip Code _____					
Home Phone _____			Referred By _____				
_____							
EMERGENCY Contact OTHER Than Parent (Name, Relationship To Child, Phone Number)							

<b>MOM'S INFO</b>	<b>DAD'S INFO</b>
Name _____	Name _____
Address _____	Address _____
City/State/ Zip _____	City/State/Zip _____
Date of Birth _____	Date of Birth _____
e-mail (optional) _____	e-mail (optional) _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
Cell Phone _____	Cell Phone _____
Employer _____	Employer _____

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

<b>INSURANCE INFORMATION</b>	
Primary Insurance: _____	Secondary Insurance: _____
Policyholder _____	Polichholder _____
Policyholder Address _____	Policyholder Address _____
Relationship To Patient _____ Copay Amt \$ _____	Relationship To Patient _____ Copay Amt \$ _____
Employer _____	Employer _____
Ins ID # _____ Group # _____	Ins ID# _____ Group # _____
Policyholder's Date of Birth _____	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...**

Signature of Patient (18+yrs) or Legal Representative _____	Relationship to Patient(s) _____	Date _____
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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.

Patient(s): (full name of all children seen by this practice)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (18+ yrs) or Legal Representative      Date                      Witness                      Date

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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 me (if 18 yrs +) or 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.

\_\_\_\_\_  
Signature of Patient (18+yrs) or Legal Representative      Date                      Witness                      Date

\_\_\_\_\_  
Please Print Name