



921 East Main St., Suite B
Purcellville, VA 20132
Phone: 540-338-3320
Fax: 540-338-2280
www.purcellvillepediatrics.com

New Patient Registration

Today's Date ____/____/____

Patient's Legal Name _____ Patient's SS# ____-____-_____
Nickname (if any) _____ Patient's Date of Birth ____/____/____ Gender M/F
Home Address _____ City _____ Zip Code _____
Home Phone (____)____-____ Email (**no personal information will be sent**) _____

Names of siblings who are patients here

Mother/Legal Guardian's Name _____
Date of Birth ____/____/____ SS# ____-____-_____
Home Address _____
Home Phone (____)____-____ Cell Phone (____)____-_____
Occupation _____ Place of Employment _____
Work Phone (____)____-____ Ext _____

Father/Legal Guardian's Name _____
Date of Birth ____/____/____ SS# ____-____-_____
Home Address _____
Home Phone (____)____-____ Cell Phone (____)____-_____
Occupation _____ Place of Employment _____
Work Phone (____)____-____ Ext _____

Preferred Pharmacy Name and Telephone Number _____

If parents are divorced, who has legal custody of child?

Who, if anyone other than the responsible party, has permission to be involved in your child's medical treatment, including bringing them in for visits?

Name and Relationship

Name and Relationship

Name and Relationship

Name and Relationship

I authorize the above listed individuals to be involved in my child's medical treatment.

Parent or Legal Guardian

Insurance Information (Please give your insurance card(s) and Photo ID to the receptionist):

Primary Insurance Company's Name _____

Policy Holder's Name _____

Member ID# _____ Group # _____

Secondary Insurance Company's Name _____

Policy Holder's Name _____

Member ID# _____ Group # _____

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Purcellville Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Purcellville Pediatrics and I direct my insurance company to pay any and all such entitlements directly to Purcellville Pediatrics.

Parent or Legal Guardian Responsible for Account

I authorize Purcellville Pediatrics to render medical care to my child. I understand that all co-pays and deductibles are to be paid at the time of service. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorney's fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Purcellville Pediatrics. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay in payment.

Parent or Legal Guardian Responsible for Account

I have received the attached "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

Parent or Legal Guardian Signature

I have received the attached "Office Policies and Procedures" and agree to its terms.

Parent or Legal Guardian Signature

Whom may we thank for referring you?
