Northern Virginia Pediatric Associates, P.C.

107 North Virginia Ave, Falls Church, VA 22046
Phone: (703) 532-4446 | Fax: (703) 532-8426

CHILD - PATIENT INFORMATION Chart # _____ (Last three digits of mom's SSN #)

Please check primary doctor:

☐ **Myers** ☐ **Barakat** ☐ **Atiyeh** ☐ **Halpin**
☐ **Mouchahoir** ☐ **Kelly** ☐ **Baldrate** ☐ **Henrikson** ☐ **Bae**

Child's Name _____ ☐ Male ☐ Female Date Of Birth _____

Home Address _____ Street _____ Phone # _____

State _____ Zip Code _____

Mother's Name _____ Date Of Birth _____

Employer _____ Work Phone # _____ Cell Phone # _____

Father's Name _____ Date Of Birth _____

Employer _____ Work Phone # _____ Cell Phone # _____

Preferred email _____ Referred by _____

Emergency Contacts _____ Name _____ Phone # _____

Name _____ Phone # _____

Health Insurance Name _____ **ID #** _____

Name of Policy Holder _____

Billing Address if Different From Home Address _____

If Divorced, Name of Parent Child Resides With _____ Phone # _____

I hereby give my permission to any of the Practice Doctors or their designated alternates, to take necessary medical action in emergency situation for my child/children when I am not immediately available. **Initials** _____

Our practice follows guidelines for immunization and routine lab tests set by the American Academy of Pediatrics. You may be responsible for partial or total payment of some of these procedures depending on your insurance coverage. Patients are responsible for knowing what their insurance company covers prior to their visit. The patient should settle any problems with coverage or reimbursement directly with the insurance company. **Initials** _____

I acknowledge that it is the policy of this office that payment is requested at each visit and I am responsible for payment of all services rendered. If the treating physician is a participant in a managed care plan of which I am a member, I agree to pay any co-payment required by my particular plan at the time of visit. **Initials** _____

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim to determine the insurance benefits to which I may be entitled. **Initials** _____

_____

Signature (Please sign, date and initial at time of first visit) **Date**