PEDIATRIC PARTNERS OF HAMPTON ROADS, PC
PATIENT PROFILE SHEET

I. Child's Name: _____
Address: _____
City, State, Zip: _____
Primary Telephone #: _____
Secondary Telephone #: _____
Email Address: _____
Would you like to sign up for patient portal? Yes No

Birth date: ____/_____/_____ SS #:_____
Nickname: _____
Gender: Male Female
Race: _____ Ethnicity: _____
Preferred Language: _____
Do you have other children that come to Pediatric Partners?
- If yes, please list names: _____

Mother's Name: _____
Address: _____
City, State, Zip_____
Employer: _____
SS#: _____***DOB:*** _____
Primary Contact #: _____

Dad's Name: _____
Address: _____
City, State, Zip: _____
Employer: _____
SS#: _____ ***DOB:*** _____
Primary Contact #: _____

Please provide front desk with a copy of your insurance information and picture id.

Primary Insurance: _____ Policy ID # _____Group # _____
Address: _____ Phone #: _____
Insured SS#: _____ Insured's Name: _____ Relationship: _____
Secondary Insurance: _____ Policy ID # _____ Group # _____
Address: _____ Phone #: _____
Insured SS#: _____ Insured's Name: _____ Relationship: _____

II. The following persons have my permission to bring the above mentioned child into Pediatric Partners of Hampton Roads, PC to receive treatment and information in my absent.

1. _____
2. _____
3. _____

III. I have read and received a copy (by request) of the following

Form A: Notice of Privacy Act
Form B: Insurance Notification
Forms C: Office Financial Policy

I authorize Pediatric Partners of Hampton Roads to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of care to third party payers and/ or other health practitioners. I authorize and direct any insurance provider to pay all benefits payable to us directly to this office (a photocopy of this agreement may be used in lieu of original). It is the responsibility of the patient/ guarantor(s) to provide this office with any future changes in insurance plans, referrals and pre-certification forms, prior to treatment, and to make certain that we are listed as you primary care provider where necessary. I acknowledge receipt of Pediatric Partners of Hampton Roads, PC notice of privacy practices. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All co-pays and deductibles are due prior to treatment. I understand that if my account is turned over to a collection attorney or a collection agency for non-payment I will be responsible for any additional fees as allowed by law.

_____ _____ _____

Signature of Patient or Parent if Minor | Social Security Number | Date