

# WOODBRIIDGE PEDIATRICS REGISTRATION FORM

Patient \_\_\_\_\_ Sex: ☐ M ☐ F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Chart# \_\_\_\_\_  
Primary Email address \_\_\_\_\_  
Preferred Pharmacy: Name, location and phone #: \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Home #: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Work #: \_\_\_\_\_

Father/Guardian \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Home #: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Work #: \_\_\_\_\_

Sibling \_\_\_\_\_ Sex: ☐ M ☐ F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sibling \_\_\_\_\_ Sex: ☐ M ☐ F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sibling \_\_\_\_\_ Sex: ☐ M ☐ F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sibling \_\_\_\_\_ Sex: ☐ M ☐ F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Children live with: ☐ Mother ☐ Father ☐ Guardian \_\_\_\_\_

## Information Requested for Purpose of Federal Compliance Reporting

Providing this information is optional. All patients receive the same medical care regardless of the answer.

### Which racial group would you place your child(ren)?

\_\_\_\_ White \_\_\_\_ African American or Black \_\_\_\_ More than one race \_\_\_\_ I prefer not to answer  
\_\_\_\_ American Indian or Alaska Native \_\_\_\_ Pacific Islander \_\_\_\_ Asian or Asian American \_\_\_\_ Other

### Which ethnic group would you place your child(ren)?

\_\_\_\_ Hispanic or Latino \_\_\_\_ Not Hispanic or Latino \_\_\_\_ I prefer not to answer  
What is your preferred language? \_\_\_\_\_ I prefer not to answer

## EMERGENCY CONTACT

Emergency Contact Person (other than parents) \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Primary \_\_\_\_\_ Claims Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Co-payment \$ \_\_\_\_\_  
Policy holder name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Policy holders address: \_\_\_\_\_ Policy holders Date of Birth: \_\_\_\_\_

Secondary \_\_\_\_\_ Claims Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Co-payment \$ \_\_\_\_\_  
Policy holders name: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Policy holders address: \_\_\_\_\_ Policy holders Date of Birth: \_\_\_\_\_

Medicaid/Champus/Other \_\_\_\_\_ Current Card # \_\_\_\_\_ Dr. listed on card: \_\_\_\_\_

PLEASE DO NOT FORGET TO READ & SIGN THE OTHER SIDE OF THIS FORM: THANK YOU



#### AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I AUTHORIZE WOODBRIDGE PEDIATRICS TO TREAT MY CHILD. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF INSURANCE FORMS. I AUTHORIZE PAYMENT DIRECTLY TO WOODBRIDGE PEDIATRICS, LTD., FOR ALL MEDICAL OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE. I ALSO AUTHORIZE THE RELEASE OF MEDICATION HISTORY FOR E-PRESCRIBING TO MY PREFERRED PHARMACY. I GIVE PERMISSION FOR MY PROVIDER TO VIEW MY CHILD'S PRESCRIPTION HISTORY FROM EXTERNAL SOURCES.

I AUTHORIZE MY HEALTH CARE PROVIDER TO USE AN AUTOMATED TELEPHONE SYSTEM AND/OR E-MAIL AND TO USE MY NAME, ADDRESS, AND PHONE NUMBER TO LEAVE A MESSAGE WITH LIMITED PROTECTED HEALTH / APPOINTMENT INFORMATION. I ALSO AUTHORIZE MY HEALTHCARE PROVIDER TO DISCLOSE TO THIRD PARTIES WHO ANSWER MY PHONE LIMITED PROTECTED HEALTH INFORMATION REGARDING PENDING APPOINTMENTS, AND TO LEAVE A REMINDER MESSAGE ON MY VOICE MAIL SYSTEM AND ANSWERING MACHINE.

I UNDERSTAND THAT I AM 18 YEARS OF AGE OR OLDER AND FINANCIALLY RESPONSIBLE FOR ALL CHARGES, CO-PAYMENTS AND ANY CHARGES NOT PAID BY MY INSURANCE.

PARENT/GUARDIAN'S (PERSON RESPONSIBLE FOR PAYMENT)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

#### AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, do hereby authorized the following individuals (over age 18 years) to schedule appointments and/or accompany my child to medical appointments **for sick care only**. They may act on my behalf regarding any medical treatment my child may need in my absence. I understand that **well care appointments require the presence of a parent or legal guardian**. Please advise the individuals listed below to bring photo identification to appointments. Authorized individuals include (name/relationship):

\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_

Signature

Date

**\*PLEASE REMEMBER ALL WELL CARE APPOINTMENTS REQUIRE THE PRESENCE OF A PARENT OR LEGAL GUARDIAN.**

#### CONSENT AGREEMENT FOR PRIVACY NOTICE

I, \_\_\_\_\_, have received a written copy of **Woodbridge Pediatrics Privacy Notice**. I also understand my rights regarding my individually identifiable health information (IIHI) as presented in the Privacy Notice and I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment, or other healthcare operations (TPO) only. Other uses of my IIHI will require an authorization form from me for the specific intention of the disclosure.

I also authorize Woodbridge Pediatrics to use the name of the patient and family members as needed for identification purposes in public areas of the office.

Patient \_\_\_\_\_

Parent Representative \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

#### ACKNOWLEDGEMENT OF ABUSE-FREE ZONE

At Woodbridge Pediatrics, we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your dismissal from our practice.

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

Signature

Date



## WOODBIDGE PEDIATRICS, LTD. Practice Policy 2017

We are committed to providing you with the best possible care and would like you to understand our policies.

For patients with participating insurance plans, all co-payments are due at time of service; a \$10 fee will be assessed for co-payments that are not paid in full at time of service. **Although your insurance may not charge a copay for Well Care, please be aware that your insurance may charge you a copay for any additional problems addressed by the Physician during Preventative Well Care.**

Payment for your office visit is required at the time of service for the following:

- Patients without insurance
- Patients with private insurance, who are not covered by one of our participating plans
- Patients who do not provide us with complete insurance information.

If you need to use a specified laboratory or x-ray facility, it is your responsibility to inform our office before the service is rendered. Any laboratory order that you have not completed within 30 days will be deleted from our system.

If you are being seen for a condition/problem that is not a covered benefit of your insurance policy, it is your responsibility to pay at time of service.

Payment is due at the time services are rendered. We accept cash, checks, and credit (MasterCard, VISA, and Discover). Returned checks will be charged a \$50 fee. There is a \$10 form fee applied for any forms that require a doctor's signature.

All accounts that have unpaid balances after 90 days will be turned over to a collection agency. You will be responsible for any fees charged by the collection agency and all costs and expenses including reasonable attorneys' fees, we incur in such collection efforts.

Woodbridge Pediatrics reserves the right to change their fees at any time.

### Release of Medical Records and Immunization History

I authorize Woodbridge Pediatrics to release and/or send medical information/records with regard to my child's health condition to other consultants and/or referring physicians, licensed healthcare facilities, health departments, and /or any education facilities as appropriate. Woodbridge Pediatrics will share immunization information with other physicians, hospitals, and health departments for purposes of ensuring that he/she receives age appropriate immunizations. Furthermore, I understand that the information may be released by forwarding a photocopy through the U.S. postal service or by confidential facsimile.

### Deemed Consent - Virginia

I understand that Virginia law (VA Code Ann. § 32.1-45.1) provides that if my physician or any person employed by my physician is exposed to my child's body fluids in a way that might possibly transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to allow testing for HIV and/or Hepatitis B or C infection. The results of this testing must be made available to the person who has been exposed to those body fluids. If the person whose blood specimen is sought for testing refuses to provide such specimen, any person potentially exposed to the HIV or hepatitis B or C viruses, or the employer of such person, may petition the general district court for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with the law.

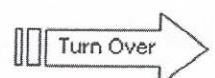
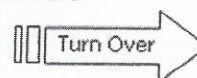
It is your responsibility to know and understand your own insurance policy. If you have any questions about our services, fees, or other aspects of your care, please do not hesitate to contact us.

I understand by signing I have **read and agree** to the above paragraphs. I understand that I am 18 years of age or older and financially responsible for all charges, co-payments and any charges not paid by my insurance.

Parent/Guardian's (Person responsible for payment)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE DO NOT FORGET TO READ & SIGN THE OTHER SIDE OF THIS FORM: THANK YOU



# WOODBIDGE PEDIATRICS, LTD

## POLICY FOR MISSED APPOINTMENTS

I, \_\_\_\_\_, a parent or legal guardian of:

List Child(ren) Name and Date of Birth:

_____ (Child's First & Last Name)	_____ Date of Birth	_____ Child's account #
_____ (Child's First & Last Name)	_____ Date of Birth	_____ Child's account #
_____ (Child's First & Last Name)	_____ Date of Birth	_____ Child's account #
_____ (Child's First & Last Name)	_____ Date of Birth	_____ Child's account #

All appointments need to be cancelled with at least 24 hours notice. If you do not cancel your appointment in the appropriate amount of time the following fees will be applied:

- **\$75.00** missed appointment fee for Well Care/Physicals
- **\$30.00** missed Physician appointments
- **\$10.00** missed Nurse appointments

I understand that if I have multiple children scheduled, each child will be charged a missed appointment fee. It is also our policy to dismiss patients who do not show up for any two scheduled appointments. Two missed appointments in a family will result in dismissal from the practice.

If you are more than 15 minutes late for your appointment we reserve the right to cancel the appointment and fees will apply.

### CONSENT AGREEMENT FOR PRIVACY NOTICE

As part of our commitment to improve the quality and the coordination of medical care for the children we serve, Woodbridge Pediatrics has elected to participate in the Children's National Health System's IQ Network. As a part of the Children's IQ Network, this written SINGLE CONSENT will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your child's treatment. Your child's healthcare information is encrypted (encoded) and can be accessed only by health care providers who are caring for your child and have a need to know. You do have the option to opt out of the Children's IQ Network. If you choose to opt out, you will need to sign a separate consent form. Please request form from receptionist if you choose to opt out.

I also authorize Woodbridge Pediatrics to use the name of the patient and family members as needed for identification purposes in public areas of the office.

I understand by signing I have **read and agree** to the above paragraphs. I understand that I am 18 years of age or older and financially responsible for all charges, co-payments and any charges not paid by my insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**WOODBRIIDGE PEDIATRICS, LTD.**  
**MEDICAL AND FAMILY HISTORY FORM**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_

Allergies/Reactions to medications, foods or vaccines: \_\_\_\_\_

Medications your child is currently taking, please include Prescriptions, Over The Counter, Herbal medications: \_\_\_\_\_

Which Pharmacy would you like your prescriptions sent to: Name, Location and Phone Number \_\_\_\_\_

**DELIVERY AND BIRTH HISTORY**

Where was your child born? Please include the Hospital and State \_\_\_\_\_

How was your child delivered? ☐ Vaginal ☐ Caesarean ☐ Adoption ☐ Other \_\_\_\_\_

If known, how old was the birth mother at time of delivery? \_\_\_\_\_

Was your child breech/feet first? ☐ Yes ☐ No

Was your child premature? If so then how many months/weeks? \_\_\_\_\_

What was your child's Birth Weight? \_\_\_\_\_ Birth Length? \_\_\_\_\_

Did your child pass the Hearing Screen? ☐ Yes ☐ No

Please indicate any medical problems during the baby's newborn period. \_\_\_\_\_

**DEVELOPMENT**

How old was your child when he/she first: Sat up without help \_\_\_\_\_, Walked without help \_\_\_\_\_,

Spoke his/her first words \_\_\_\_\_

Please check off any concerns you have: ☐ Physical Development, ☐ Speech, ☐ School Performance

Briefly state any developmental concerns/issues you would like to speak to the provider about \_\_\_\_\_

**PAST MEDICAL HISTORY**

Has your child ever been hospitalized overnight? ☐ No ☐ Yes, when and why \_\_\_\_\_

Has your child ever had surgery? ☐ No ☐ Yes, when and why \_\_\_\_\_

Has your child ever had a serious injury? ☐ No ☐ Yes, when and why \_\_\_\_\_

Is your child effected by any of the following? (check all that apply) ☐ My child has No Significant Past Medical History

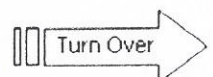
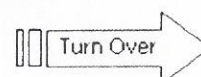
☐ ADD/ADHD ☐ Anemia ☐ Autism ☐ Broken Bones ☐ Chicken Pox ☐ Concussions ☐ Constipation

☐ Diarrhea ☐ Diabetes ☐ Depression ☐ Ear Infection ☐ Eczema ☐ Food Allergies ☐ Heart Murmur

☐ Heart Disease ☐ Hearing Loss ☐ Rashes ☐ Reflux/GERD ☐ Seasonal Allergies ☐ Sickle Cell Anemia

☐ Seizures ☐ Urinary Problems ☐ Vaccine Reactions ☐ Wheezing/Asthma ☐ Other issues (explain) \_\_\_\_\_

**PLEASE DO NOT FORGET TO FILL OUT THE OTHER SIDE OF THIS FORM. THANK YOU**



## SOCIAL HISTORY

Who does your child live with? \_\_\_\_\_

Are the Parents    ☐ Married    ☐ Unmarried    ☐ Separated    ☐ Divorced

Was the house your child lives in built before 1978?    ☐ No    ☐ Yes

Do you have a pool?    ☐ No    ☐ Yes

Are there any guns in the home?    ☐ No    ☐ Yes

Are there any pets in the home?    ☐ No    ☐ Yes

Does your child go to a babysitter or attend daycare?    ☐ No    ☐ Yes

Is your child in after school care?    ☐ No    ☐ Yes

Are there any smokers in the home?    ☐ No    ☐ Yes    If so, where do they smoke? \_\_\_\_\_

Have you been exposed to anyone with TB (Tuberculosis) ?    ☐ No    ☐ Yes

Any foreign travel within the past five years?    ☐ No    ☐ Yes    If so, when, where and for how long? \_\_\_\_\_

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## FAMILY HISTORY

Please state which of the following relatives have the conditions below (if none leave blank)

Please enter **M**=Mother, **F**=Father, **G**=Grandparent, **B**=Brother, **S**=Sister, **A**=Aunt, **U**=Uncle

☐ Asthma    ☐ Anemia    ☐ Allergies    ☐ ADD/ADHD    ☐ Autism    ☐ Auto Immune disorder  
☐ Birth defects    ☐ Blood Disorders    ☐ Chicken Pox    ☐ Cystic Fibrosis    ☐ Cancer    ☐ Diabetes  
☐ Depression    ☐ Ear infection    ☐ Eczema    ☐ Epilepsy    ☐ GI Disease    ☐ High Cholesterol  
☐ Heart Disease    ☐ Hearing Problem    ☐ Heart Murmur    ☐ High Blood Pressure    ☐ Kidney Disorder  
☐ Liver Disease    ☐ Migraine Headaches    ☐ Reflux/GERD    ☐ Rashes    ☐ Seizures    ☐ Sickle Cell  
☐ Stroke before 55    ☐ Sudden Death    ☐ Thyroid Disease    ☐ Tuberculosis    ☐ Urinary Problems  
☐ Vision Problems

Other information you feel the physician should know about your child? \_\_\_\_\_

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