AAA Pediatrics

2200 Opitz Blvd. Suite 355, Woodbridge VA 22191 Phone: 703-580-6400 Fax: 703-580-4550

Patient Registration

Patient(s) name:

1. _____ DOB: _____ Male /Female
2. _____ DOB: _____ Male /Female
3. _____ DOB: _____ Male /Female
4. _____ DOB: _____ Male /Female
5. _____ DOB: _____ Male /Female

Primary address: _____

City: _____ **State:** _____ **Zip code:** _____

E-mail address: _____ (the email of the person who will receive notifications)

Who holds financial responsibility? (The person who will receive all the statements) ☐ Mom **OR** ☐ Dad **ONLY ONE**

Mother/ Legal Guardian **Lives with** ☐ **YES** ☐ **NO**

First name: _____ **Last name:** _____

DOB: _____ **SSN:** _____

Address if different from Primary: _____

City: _____ State: _____ Zip code: _____

Telephone number: _____ (cellular / work / home) Primary number ☐ YES ☐ NO

Father/ Legal Guardian **Lives with** ☐ **YES** ☐ **NO**

First name: _____ **Last name:** _____

DOB: _____ **SSN:** _____

Address if different from Primary: _____

City: _____ State: _____ Zip code: _____

Telephone number: _____ (cellular / work / home) Primary number ☐ YES ☐ NO

Emergency contact: _____

Relation to patient: _____ Phone number: _____

Primary Pharmacy: _____ Phone number: _____

Address: _____

RACE – Circle all that apply:

*Black/African American *Asian *Central American Indian *Hispanic/Latin *South American Indian *White

*Other _____ *Refuse to Answer

ETHNICITIES – Circle all that apply:

*Central American *Decline to Specify *Hispanic or Latino *Not Hispanic or Latino *Refused to Report *South American

Primary insurance:

Name of insurance: _____ Member ID: _____ Group No. _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Subscriber's Employer name: _____ Phone number: _____

Employer complete address: _____

Secondary Insurance:

Name of insurance: _____ Member ID: _____ Group No. _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Subscriber's Employer name: _____ Phone number: _____

Employer complete address: _____

People authorized to bring patient(s) to office (they **MUST** bring a valid ID)**:**

1. _____ Relation to patient: _____phone number: _____
2. _____ Relation to patient: _____phone number: _____
3. _____ Relation to patient: _____phone number: _____
4. _____ Relation to patient: _____phone number: _____

I hereby authorize physicians of AAA Pediatrics, Nurse Practitioner, under the supervision of physician to render medical treatment, which in his/her judgment may be deemed necessary for the care of the children named on this form. I certify that the information I have reported is true and correct. As the Parent/Guardian/Guarantor I have read; understand and fully accept the Conditions of Registration Form, the current Office Policies in paper and/or confirmed with my signature at the KIOSK at every sign-in. I acknowledge that I have been given the opportunity to review a copy of the "Notice of Privacy Practices" at my request. ***In cases of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring the child (ren) in for exams, and have full access to the child's medical records.***

PRINT - Mother/ Legal Guardian _____

Signature_____ ***Date***: _____

PRINT - Father/ Legal Guardian _____

Signature_____ ***Date***: _____