

PIEDMONT PEDIATRICS



PIEDMONT PEDIATRICS, PLC
20 Rock Pointe Lane
Warrenton, VA 20186
540-347-9900

PATIENT INFORMATION

NAME (Last, First Middle)	SS#	BIRTHDATE	SEX
LOCAL ADDRESS - No PO Boxes	SECONDARY ADDRESS (if applicable)		
CITY, STATE ZIP	CITY, STATE, ZIP		
HOME PHONE	CELL PHONE		

RESPONSIBLE PARTY INFORMATION

NAME (Last, First, Middle)	SS#	BIRTHDATE	SEX
_____ CHECK HERE IF ADDRESS IS EXACTLY AS THE PATIENT	EMPLOYER NAME		
ADDRESS	ADDRESS		
CITY, STATE, ZIP	CITY, STATE, ZIP		
HOME PHONE	WORK PHONE		
RELATIONSHIP TO THE PATIENT	PATIENT EMERGENCY CONTACT NAME & PHONE		

PRIMARY INSURANCE INFORMATION

DOES YOUR CHILD HAVE VIRGINIA MEDICAID COVERAGE? _____ YES _____ NO

IF YES, PLEASE CHOOSE ONE:

___ HEALTHKEEPERS PLUS ___ AMERIGROUP ___ VA PREMIER ___ STANDARD MEDICAID ___ OTHER _____

IF NO – PLEASE COMPLETE:

NAME OF INSURANCE COMPANY	POLICY #
NAME OF INSURED PERSON	GROUP #
CLAIMS ADDRESS	CO-PAY AMOUNT
CITY, STATE, ZIP	EFFECTIVE DATE OF COVERAGE
INSURED PERSON'S RELATIONSHIP TO PATIENT	EXPIRATION DATE OF COVERAGE

DOES THE PATIENT HAVE MEDICAID AS A SECONDARY INSURANCE? YES NO

IF YES: ID NUMBER EFFECTIVE DATE OF COVERAGE

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid instead directly to Piedmont Pediatrics, PLC and it's providers for services rendered. I further authorize the release of any information needed in processing my insurance claims. An electronic or paper copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company, including special fees that I may incur such as returned checks, delinquent balances, collection fees, faxing service, long distance phone calls, telephone consults and lengthy forms, applications and/or letters. I also recognize that if we habitually miss scheduled appointments that I may be charged a missed appointment fee.

INFORMATION ON THIS FORM MAY ONLY BE CHANGED BY FILLING OUT AND DATING ANOTHER FORM.

Signature of Parent or Legal Guardian of Patient

Date