Pediatric Consultants of Hampton Roads
Insurance Information

Patient Name: _____ Date of Birth: _____ M ____ F ___

Home Address: _____

Primary Insurance:

Insurance Subscriber Name: _____Social Security #: _____ _____ _____ DOB: ____/____/____
(Name of person who carries the insurance)

Health Plan: _____ Group #: _____ ID #:_____

Date Coverage Effective: ____/____/____

Secondary Insurance:

Insurance Subscriber Name: _____Social Security #: _____ _____ _____ DOB: ____/____/____
(Name of person who carries the insurance)

Health Plan: _____ Group #: _____ ID #: _____

Date Coverage Effective: ____/____/____

Insurance Policy

I understand it is my responsibility to provide the accurate information and updated insurance cards to the physician's office at the time of service. I authorize PCHR to release all information necessary to secure payments of benefits to my health insurance company. I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment I am fully responsible for payment of medical services rendered to my child. I will also be responsible for all customarily assessed fees by collection agencies. I agree to pay all applicable health plan co-payments at the time of service. I assign PCHR all insurance benefits. I have received HIPPA Notice of Privacy from PCHR.

Signature _____ Date _____

Name of person responsible for insurance premiums:

Name: _____ DOB: _____ SSN: _____

PEDIATRIC CONSULTANT OF HAMPTON ROADS

Patient's Name: _____ Patient's Date of Birth: _____ Male _____ Female _____

Patient's Home Address: _____

Home Phone Number: (_____) _____ Email Address: _____

Race: □ Caucasian / White
□ Black / African American
□ Asian
□ American Indian / Alaskan Native
□ Pacific Islander
□ Native Hawaiian
□ More than one race
□ Unreported / Refused

Ethnicity: □ Hispanic / or Latino
□ Non- Hispanic
□ Unreported / or Refused to Report

Language: □ English
□ Spanish
□ Vietnamese
□ Other: _____

Patient lives with: □ Both Parents □ Mother □ Father □ Other: _____

Mother's Information	***Father's Information***
Name:	Name:
DOB:	DOB:
SSN:	SSN:
Home Address: City: State: Zip:	Home Address: City: State: Zip:
Employer:	Employer:
Occupation:	Occupation:
Home #: Cell #: Work #:	Home #: Cell #: Work #:
Race: Ethnicity: Language:	Race: Ethnicity: Language:

Emergency Contact

I, _____, authorize the following person (s) to accompany the patient for:

Routine Health Visits_____ Sick Visits _____ Shots _____ Blood Work _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I, _____, authorize Pediatric Consultants of Hampton Roads to **release** my child's medical information to:

- _____
  (Full Name) *(Relationship to child?)* *(Phone Number)*
- _____
  (Full Name) *(Relationship to child?)* *(Phone Number)*

Signature: _____ **Date: _____**

ALL FIELDS MUST BE COMPLETED