Chester Pediatrics, P.C.

Pediatric and Adolescent Medicine

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9330 Ironbridge Rd chesterfield, VA 23832
PH: 804-717-5540 Fax: 804-717-5525

Patient's Name: **DOB:**

Patient's Address_____

Patient resides with: ☐ **Mom and Dad** ☐ **Mom** ☐ **Dad** ☐ **Other** _____

Home Phone: _____ **Cell Phone:** _____ **E-mail:** _____

Mother's Name: _____ **DOB:** ___/____/____ **SSN#**_____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Employer: _____ **E-mail:** _____

Father's Name: _____ **DOB:** ___ /____/____ **SSN#**_____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Employer: _____ **E-mail:** _____

Sibling Information:

First & Last name:_____ DOB: _____ Sex: ☐ M ☐ F Sibling resides with patient: ☐ YES ☐ NO

First & Last name:_____ DOB: _____ Sex: ☐ M ☐ F Sibling resides with patient : ☐ YES ☐NO

First & Last name:_____ DOB: _____ Sex: ☐ M ☐ F Sibling resides with patient: ☐ YES ☐ NO

First & Last name:_____ DOB: _____ Sex: ☐ M ☐ F Sibling resides with patient: ☐ YES ☐ NO

Insurance Information:

Primary Insurance: _____ID#: _____

Subscriber name_____

2nd Insurance: _____ID#: _____Subscriber name: _____

I understand that whenever any health care provider is exposed to blood or body fluid in any manner that may transmit a communicable disease, the person whose body fluids were involved in the exposure shall be deemed to have consented testing for communicable disease(s) in concern.

I hereby authorize Chester Pediatrics, P.C. to release medical information to other physicians and my insurance company set forth in the notice of Privacy Practices which has been provided by Chester Pediatrics.

The undersigned, in consideration of his/her relationship to the patient, and of Chester Pediatrics, P.C. rendering services to said patient, undertakes to be financially responsible for and agrees to pay upon request of statement thereof, for all services rendered to the patient.

I hereby authorize payment directly to Chester Pediatrics, P.C. of benefits otherwise payable to me. I understand that in the event my account is turned over to any attorney for collection, that I shall be responsible for attorney's fees and court costs.

Date:_____ Parent's Signature _____