Western Loudoun PEDIATRICS

PATIENT REGISTRATION

Child's Name	M/F	Date of Birth	Main Language	Ethnicity (optional)	Race (optional)	Choices for Race: 1-American Indian 2-Asian 3-Black/African American 4-More than one Race 5-Native Hawaiian 6-Other Pacific Islander 7-White
				Hispanic Not Hispanic		
				Hispanic Not Hispanic		
				Hispanic Not Hispanic		

Patient Information	
Address	
City/State/Zip	
Home Phone	

Parent/Guardian Information	Primary Contact Parent	Parent 2
Name		
Relationship to Patient	Mother Father Step-Parent Guardian	Mother Father Step-Parent Guardian
Date of Birth		
Level of Responsibility	Joint Exclusive Emergency Only Financial Only None	Joint Exclusive Emergency Only Financial Only None
Resides with Patient	Yes No	Yes No
Primary Language		
Cell Phone #		
Email		
Occupation & Work Phone #		

Contact Preferences for Primary Parent:		
Medical Issues	Home # Cell #	Is it okay to leave a message? Yes No
Appointment reminders	Home # Text to Cell# Email	
Well visit recalls	Email Text to Cell#	
General Notices	Home # Cell #	
Patient Portal	Home # Cell #	

Insurance Information		
	Primary	**Secondary**
Insurance Name		
Guarantor Name*		
Guarantor SSN*		
ID #		
Group #		

I state that I am the natural parent or legal guardian of the patient(s) listed above. The information above is accurate and I understand that I must notify Western Loudoun Pediatrics in writing of any changes to the above.

Signature _____ Relationship _____

Print Name _____ Date _____