Screened Areas For Office Use Only

HOH ACCT. NO.	STMT	NETWORK:

FPA

FAIRFAX PEDIATRIC ASSOCIATES, P.C.

DATE _____/_____/_____

☐ NEW FAMILY ☐ CHANGE ADDRESS ☐ CHANGE INSURANCE

	FIRST NAME	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
FATHER'S				
MOTHER'S				

ADDRESS: Street _____

City _____ State _____ Zip _____

HOME PHONE	(_____) _____	WORK PHONE	EMPLOYER
FATHER'S CELL	(_____) _____	(_____) _____	_____
MOTHER'S CELL	(_____) _____	(_____) _____	_____

HOME E-MAIL _____

PARENT: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated REFERRED BY: _____

EMERGENCY CONTACT _____ EMERGENCY PHONE # _____

AUTHORIZATION FOR TREATMENT

I hereby authorize any Physician of Fairfax Pediatric Associates, P.C.; Nurse or Nurse Practitioner under the supervision of a Physician of Fairfax Pediatric Associates, P.C., to render medical treatment, which in his/her judgement may be deemed necessary for the care of the following children:

CHILDREN

ACCT. NO.	INS.	First Name	MI	Last Name	SEX M	SEX F	DATE OF BIRTH MO/DAY/YR	KNOWN ALLERGIES
					☐	☐	/ /	
					☐	☐	/ /	
					☐	☐	/ /	
					☐	☐	/ /	
					☐	☐	/ /	

Signature of Parent or Guardian _____ Date _____

PRIMARY INSURANCE

CODE	NOTES:

INS. CO. NAME _____

TELEPHONE (_____) _____

GROUP # _____

ID # _____

EFFECTIVE DATE _____ COPAY: _____

WHICH PARENT PAYS FOR THE INSURANCE POLICY FOR THE CHILDREN?
☐ MOTHER ☐ FATHER ☐ STEP-PARENT

NAME OF INSURED PARENT: _____

DATE OF BIRTH OF INSURED PARENT: _____

EMPLOYER: _____

SECONDARY INSURANCE

CODE	NOTES:

INS. CO. NAME _____

TELEPHONE (_____) _____

GROUP # _____

ID # _____

EFFECTIVE DATE _____ COPAY: _____

WHICH PARENT PAYS FOR THE INSURANCE POLICY FOR THE CHILDREN?
☐ MOTHER ☐ FATHER ☐ STEP-PARENT

NAME OF INSURED PARENT: _____

DATE OF BIRTH OF INSURED PARENT: _____

EMPLOYER: _____

LIFETIME AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request the payment of insurance benefits be made on my behalf to Fairfax Pediatric Associates for any services furnished to my child(ren) by the physician of FPA who accepts this assignment. I authorize any holder of medical information about my child(ren) to release to my insurance carrier any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I will pay for any balance due on services rendered which are not covered by my insurance plan. If my account is released to a collection agency for non-payment of any balances, I will be responsible for the collection agency's fee.

Signature: _____ Date: _____