Renaissance Pediatrics, P.C.
4012 Raintree RD, Suite 200A
Chesapeake, VA 23321
Office: 757.488.2223 Fax: 757.488.8398

Patient's Name: _____
First Middle Last

Gender: □ M □ F □ O Ethnicity: □ Hispanic □Non-Hispanic

Race:_____Preferred Language: _____

Email Address: _____

I am 18 years or older and I □ give / □ do not give access to my records to the following people: _____

_____

Birth Date:_____/_____/_____SSN:_____

Address:_____

City, State, & Zip: _____

Primary Telephone:_____Type: □ H □C □ W

Secondary Telephone:_____Type: □ H □C □ W

I prefer to be reminded of appointments by:

□ Phone □ Email □ Text

□ Mother □ Father □ Guardian □ _____

Name:_____

Address:_____

City, State, & Zip: _____

Employer:_____Home #: _____

Cell #:_____Work #:_____Preferred #: □ H □C □W

SSN:_____DOB: _____

□ Mother □ Father □ Guardian □ _____

Name:_____

Address:_____

City, State, & Zip: _____

Employer:_____Home #: _____

Cell #:_____Work #:_____Preferred #: □ H □C □W

SSN: _____ DOB: _____

Primary Insurance Company: _____

Group #:_____Policy ID #: _____

Co-Pay:_____Deductible:_____Eff. Date: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Birthdate:_____/_____/_____SSN: _____

Secondary Insurance Company: _____

Group #:_____Policy ID #: _____

Co-Pay:_____Deductible:_____Eff. Date: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Birthdate: _____/____/_____ SSN: _____

I give the following person(s) permission to seek medical care for the above mentioned patient in my absence. This is to be effective on the date signed and will remain in effect until further notice is given. The listed person(s) should also be considered "emergency contacts."

Name	Relationship	Phone #

I authorize Renaissance Pediatrics, P.C. to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me

.I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **If it becomes necessary to forward my account to a collection agency, I am aware that I will be responsible for all costs of collections, which is currently $25.00 (subject to change).**

_____ _____ _____
Signature of Patient or Parent if Minor Social Security Number Date