Infinity
Pediatric & Adolescent Medicine

1809 S. Church Street
Suite 302
Smithfield, VA 23430
Phone: 757-780-8400
Fax: 757-432-3279

Patient and Family Information

Child 1: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White ☐Other ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Insured Name: _____

Insured Adress: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Insured Name: _____

Insured Adress: _____

Child 2: Last Name: _____ First Name: _____ MI: ____

DOB: ____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White ☐Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Insured Name: _____

Insured Adress:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Child 3: Last Name:_____First Name:_____MI: ____

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White ☐Other ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Child 4: Last Name:_____First Name:_____MI: ____

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐African American ☐American Indian or Native Alaskan ☐Asian

☐Hawaiian or Pacific Islander ☐White Other ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Primary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Insured Name:_____

Insured Adress:_____

Pharmacy Name:_____ Pharmacy Phone #: _____

Parent/Legal Guardian #1:

Child(ren)'s parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widow(er) ☐ Other

Name:_____Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone:_____Email: _____

Employer:_____Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐ Work

Infinity Pediatric & Adolescent Medicine may contact me via: ☐Home ☐Cell ☐Work ☐Email

Infinity Pediatric & Adolescent Medicine may leave messages or lab results via: ☐ Home ☐Cell ☐ Work ☐ Email

Lives with patient? Yes / No

_____

(Street) *(City/State/Zip)*

Parent/Legal Guardian #2:

Name: _____ Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone:_____Email: _____

Employer:_____Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐ Work

Infinity Pediatric & Adolescent Medicine may contact me via: ☐ Home ☐ Cell ☐Work ☐ Email

Infinity Pediatric & Adolescent Medicine may leave messages or lab results via: ☐Home ☐Cell ☐Work ☐Email

Lives with patient? Yes / No If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1):

_____

(Street) *(City/State/Zip)*

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? Yes / No

If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Emergency Contacts, other than parents. Name & Relationship:

Name:_____Phone: _____

Name:_____Phone: _____