ACCT #_____

8630 FENTON STREET, SUITE 230
SILVER SPRING, MD 20910
PHONE: (301) 565-3999

Virgo - Carter Pediatrics

GABRIELLE VIRGO, M.D., FAAP
ERNEST CARTER, M.D., PH.D., FAAP

WELCOME TO OUR OFFICE!

DATE:

NEW PATIENT? YES NO

PATIENT INFORMATION

CHILD'S NAME - (LAST) (FIRST) (MIDDLE)	DATE OF BIRTH	SEX	AGE	CHILD'S SOCIAL SECURITY NUMBER
	/ /	M F		– –

HOME ADDRESS OR P.O. BOX APT.	CITY STATE ZIP CODE	HOME PHONE
		( )

CELL PHONE FOR 16 YR AND UP	EMAIL ADDRESS FOR 16 YR AND UP	SCHOOL NAME	GRADE
( )			

DATE OF INJURY OR ILLNESS ONSET	CURRENT MEDICATIONS	ALLERGIES • ENVIRONMENT • FOOD • MEDICATION

MOTHER'S NAME	HOME ADDRESS (IF DIFFERENT)	CITY STATE ZIP CODE	MOTHER'S SOCIAL SECURITY NUMBER
			– –
MOTHER'S EMPLOYER	WORK ADDRESS	CITY STATE ZIP CODE	DAYTIME PHONE
			( )
CELL PHONE	EMAIL ADDRESS		
( )			

FATHER'S NAME	HOME ADDRESS (IF DIFFERENT)	CITY STATE ZIP CODE	FATHER'S SOCIAL SECURITY NUMBER
			– –
FATHER'S EMPLOYER	WORK ADDRESS	CITY STATE ZIP CODE	DAYTIME PHONE
			( )
CELL PHONE	EMAIL ADDRESS		
( )			

EMERGENCY CONTACT	ADDRESS	EMERGENCY PHONE	RELATIONSHIP
		( )	
PHARMACY NAME		PHARMACY #	PHARMACY PHONE
			( )
ADDRESS		CITY	STATE ZIP CODE

HEALTH INSURANCE

(PLEASE HAVE INSURANCE CARDS AVAILABLE) (DO NOT FORGET TO ADD YOUR NEW BABY TO INSURANCE PLAN)

PRIMARY INSURANCE NAME	POLICY HOLDER'S NAME	DATE OF BIRTH	EMPLOYER NAME, IF GROUP INSURANCE
		/ /	

INSURANCE ADDRESS	ID / POLICY NO.	INSURANCE PHONE #
		( )

CITY STATE ZIP CODE	GROUP NO.	CO-PAYMENT	

Authorization to apply for benefits / Financial Agreement / Release of Medical Records / Consent

I hereby give my consent to Drs. Virgo & Carter to provide procedures or treatment to my child as medically necessary.

I authorize Virgo-Carter Pediatrics to apply for benefits on my behalf for services provided. I request that payment of benefits authorized by my insurance or other third party or governmental agency, be made directly to Virgo-Carter Pediatrics.

I authorize the release of medical information relevant to these services when required by my insurance for determining eligibility of benefits. Virgo-Carter Pediatrics, their agents and employees are released from all liability that may arise from the release of such information.

I guarantee prompt payment of all costs associated with services rendered by Virgo-Carter Pediatrics which are not covered or not authorized by my insurance. ***Furthermore, should I fail to satisfy a financial obligation for which I am personally responsible, Virgo-Carter Pediatrics reserves the right to terminate the physician-patient relationship and provide a list of substitute physicians to replace the existing physician.*** If any unpaid balance is referred to an attorney for collection, I agree to pay reasonable legal fees, court costs, and collection expenses. Balances remaining unpaid for 90 days, for which I am responsible, may accrue interest charges at a rate permitted by applicable law.

DATE:_____ SIGNATURE OF PARENT OR GUARDIAN:_____