KinderLife PEDIATRICS

Mi Hei Chung Cho, M.D.
14631 Lee Hwy, Suite 413
Centreville, VA 20121

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ Sex: _____

DEMOGRAPHIC INFORMATION

Preferred Language: _____

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Prefer Not to Answer

Race

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White or Caucasian

☐ Prefer Not to Answer

Parents or Legal Guardian Information

Relation to Patient: ☐ Mom ☐ Dad ☐ Other: _____ Is this the responsible party? ☐ Yes ☐ No

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Other Parents/Legal Guardian

Relation to Patient: ☐ Mom ☐ Dad ☐ Other: _____ Is this the responsible party? ☐ Yes ☐ No

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Phone #: _____

Insurance Policy Information:

Policy Holder's Name: _____ Relation to Patient: _____

Insurance Name: _____

Insurance Policy ID: _____ Group #: _____

Policy Holder's DOB:_____ Policy Holder's SSN: _____

Policy Holder's Address **(If different from Parents' Information)**

Address: _____ City: _____ State: _____ Zip: _____

Do you have any Secondary Insurance?: _____

I authorize the release of my child's information necessary to process the claim, I permit a copy of this authorization to be used in the chart in place of original. I hereby authorize Kinder Life Pediatrics to apply for benefits on my behalf for the coverage services rendered or ordered by Kinder Life Pediatrics. I request that payment from my insurance company be made to Kinder Life Pediatrics. I certify that the information I presented with regard to my insurance is correct. Either I or my insurance company at any time, in writing, may revoke this authorization.

Signature: _____ Date: _____

Consent for Treatment

I give consent to treatment and medical care of my children as listed above by Dr. Mi Hei Chung Cho, who will perform treatments that in her judgment is deemed medically necessary. I will be financially responsible for services rendered including office visit, labs, tests, forms, and other incurred charges.

Signature: _____ Date: _____