# Welcome

## Annandale Pediatrics Associated, LTD.

**Patient's Information:**

Name:_____ Address_____
Birthday:_____ _____
Child's Nickname:_____ Sex: ___Male ___Female
Other Sibling&DOB:_____ School/Phone:_____
_____ _____

**Parent's Information:** _Married _Divorced _Separated _Remarried __Single

Mother: ___Stepmother ___Guardian Birthday:_____
Name:_____
Mother's Address:_____ Home Phone: ( ) -
_____ Work Phone: ( ) -
Employer:_____ Social Security #:_____
Address:_____

Father: ___Stepfather ___Guardian Birthday:_____
Name:_____ Home Phone: ( ) -
Address:_____ Work Phone: ( ) -
Employer:_____ Social Security #:_____
Address:_____

Who has legal custody of the child:_____
Is the child adopted? ___Yes ___No
If the child is an infant who was the OB/GYN?_____

**Person Responsible for the account:**

Name:_____ Relationship to Patient:_____
Social Securtiy #:_____ Home Phone: ( ) -
Billing Address:_____ Work Phone: ( ) -
_____ Employer:_____

**Insurance Company:**

Name:_____ Policy #:_____
Policy Holder:_____
Secondary Insurance:_____ Policy #:_____

***I agree to be responsible for full payment of charges incurred as well as any legal fees required for collection of the same. I am also responsible to inform Annandale Pediatrics Assoc. of any changes in the above information.***

Signature of Parent/Guardian:_____Date:_____