

Pediatric Associates of Williamsburg



a practice of

**Children's Hospital
of The King's Daughters**

Health System

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Patient Information

(for office use only) Epic #: _____ AcSel #: _____

Patient Name: _____

Social Security #: _____ Birth Date: _____

Mailing Address: _____ City, State: _____ Zip: _____

Home Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: F M Marital Status: M S D W

Emergency Contact: _____ Telephone #: _____

Responsible Party Information

Responsible Party Name: _____

Social Security #: _____ DOB: _____ Email address: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employed By: _____

Primary Insurance

Subscriber's Name & Address: _____ Subscriber DOB: _____

Employer Name & Address: _____

Insurance Company: _____

Subscriber #: _____ Group #: _____ Plan #: _____

Relationship to Subscriber: Self Spouse Child Other, describe: _____

Secondary Insurance

Subscriber's Name & Address: _____

Employer Name & Address: _____

Insurance Company: _____

Social Security #: _____ Group #: _____ Plan #: _____

Relationship to Subscriber: Self Spouse Child Other, describe: _____

Do you have an Advanced Directive/Living Health Will? Yes No

(For office use only) Date entered in system: _____ Initials: _____