Boulevard Center Pediatrics – Shailesh Gohel, MD, FAAP
3733 Fettler Park Dr. Dumfries, VA 22025 Tel. (703) 670-0300 Fax: (703) 291-5331 www.boulevardcenterpediatrics.com

REGISTRATION FORM

	Name of Child(ren)	Sex: (M/F)	Date of Birth (MM/DD/YY)
1.			
2.			
3.			
4.			

Preferred Pharmacy:_____ **Address & Tel. No:**_____

Race (please circle): African American Caucasian/White Hispanic Asian Other_____

Mother/Legal Guardian Information: Do patient(s) live with this guardian/mother? Circle One: Yes No

Mother Name:_____ D.O.B._____ SSN:_____

Home Address:_____ City:_____ State/Zip_____

Phone: Home_____ ___ Cell_____Work_____ Email:_____

Employer Name:_____

Employer Address:_____ Tel. No._____

Father/Legal Guardian Information: Do patient(s) live with this guardian/father? Circle One: Yes No

Father Name:_____ D.O.B._____ SSN:_____

Home Address:_____ City:_____ State/Zip_____

Phone: Home_____ ___ Cell_____Work_____ Email:_____

Employer Name:_____

Employer Address:_____ Tel. No._____

Name of Primary Insurance Company:_____

Name of Insured:_____**D.O.B.**_____**SSN:**_____

Member ID:_____ Group ID_____ PCP Required?: Yes No

Is Insurance thru (circle one): Place of Employment Privately Purchased (ACA) Medicaid Other:_____

Emergency Contact: (For contact purposes only in the event of an emergency)

Name:_____ Relation:_____Tel. No:_____

Permission/Consent for other adults (ages 18+) to bring patient(s) for medical care: *I give permission to the individuals listed below to bring my child(ren) for medical care, authorize them to make decisions for necessary treatment(s), procedures and immunizations for my child(ren).*

Name/Relation:_____ **Name/Relation:**_____

I hereby authorize Physicians of Boulevard Center Pediatrics, Inc. Nurse or Nurse Practioner under the supervision of physician to render medical treatment, which in his/her judgment may be deemed necessary for the care of my children named on this form. I certify that the information I have reported is true and correct. As the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on the Conditions of Registration Form and the current Office Policies. I acknowledge that I have been given and opportunity to review a copy of the "Notice of Privacy Practices." *In case of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring child(ren) for exams and have full access to the child's medical records.

_____ _____

Mother/Legal Guardian Signature **Date** **Father/Legal Guardian Signature** **Date**