

Valley Internal Medicine and Pediatrics
Pediatric New Patient Forms

Patient Name _____ DOB _____ ☐ Female ☐ Male
Address _____ Pharmacy _____
City, State, Zip _____ Emergency Contact:
Phone _____ Name _____
Phone _____ Phone _____
Email _____ Relationship _____
Is child currently in foster care ☐ Yes ☐ NO

☐ Yes ☐ NO I authorize VIMP contact me by phone or text to discuss personal health information at the phone numbers provided.

☐ Yes ☐ NO I authorize the disclosure of personal health information to certain individuals other than myself as listed below:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Insurance Information:

☐ Self-Pay

Primary _____	Secondary _____
MemberID _____	MemberID _____
Group# _____	Group# _____
Policy Holder _____	Policy Holder _____
DOB _____	DOB _____
Relationship _____	Relationship _____

The above information is true to the best of my knowledge: I hereby authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Valley Internal medicine and pediatrics to release information necessary to secure the payment and benefits. I authorize the use of my signature on all insurance submissions.

Printed Name _____ Sign _____ Date _____

**Valley Internal Medicine and Pediatrics Financial/ office policies:
(please initial below)**

_____ All copays/deductibles/balance due at time of visit
_____ All return checks \$35 charge
_____ No Show appointments \$35
_____ FMLA \$25
_____ Blue Cards \$5
_____ PA's \$25

Medical Information:

Allergies _____

Past Medical/surgical history: _____

Medications: _____

Social History:

Lives with _____ Relationship _____

Smoking in the home: ☐ Yes ☐ NO

For Newborn appointments:

Hospital child born: _____

Mother Gestational age at delivery: _____

Birthweight: _____

Hep B Given in Hospital ☐ Yes ☐ No

☐ Breast Fed ☐ Formula Fed ☐ Both

Any complications: _____

Mother Name: _____ Ok to discuss child medical info ☐ Yes ☐ No

Father Name: _____ Ok to discuss child medical info ☐ Yes ☐ No

Foster Parent Name: _____

I authorize that I have read the above office policies and know that I have access to Notice of privacy practice/ HIPAA and I agree to the authorization to treat.

Printed Name _____ Sign _____ Date _____

Medical Records Release Authorization

I hereby authorize and request you to release a medical records needed to:

Valley Internal Medicine and Pediatrics
708 Will Halsey Way Suite A Madison, Al 35758
Ph: (256) 325 7425 Fax: (256) 325 2765

Patient Full Name_____ DOB_____

If not patient: Name_____ Relationship_____

Name of physician from whom we are requesting records:

Purpose for disclosing records_____

Records Needed_____

Patient signature _____

Parent or guardian signature_____

Date_____