CHILDREN'S HEALTH CARE CENTER OF NORTHERN VIRGINIA
Bryan McEachern, MD
9001 Digges Road, Suite 106
Manassas, VA 20110
PHONE: 703-392-5437 FAX: 703-392-0176

Child's Full Name

1. ______________________________DOB______________Male___Female___

Race______________Ethnicity________________Preferred Language________________

2. ______________________________DOB______________Male___Female___

Race______________Ethnicity________________Preferred Language________________

3. ______________________________DOB______________Male___Female___

Race______________Ethnicity________________Preferred Language________________

4. ______________________________DOB______________Male___Female___

Race______________Ethnicity________________Preferred Language________________

5. ______________________________DOB______________Male___Female___

Race______________Ethnicity________________Preferred Language________________

Household Pharmacy & Location (address) ____

Parent/Guardian Responsible for Charges

Last Name______________________________ **First Name** ______________________________

SS# ______________________**DOB** ____________________ **Home PH** ____________________

Address ____ **Cell PH** ____________________

City __________________________ **State** ________ **Zip** __________________

Employer ____ **Work PH** ____________________

EMAIL ____

Other Parent/Guardian Information

Last Name______________________________ **First Name** ______________________________

SS# ______________________**DOB** ____________________ **Home PH** ____________________

Address ____ **Cell PH** ____________________

City __________________________ **State** ________ **Zip** __________________

Employer ____ **Work PH** ____________________

Email ____

Emergency Contact other than parents: __________________________ **Phone** ________________

Address ____ **Relationship** ____________________

Assignment of Benefits

I authorize payment directly to Children's Health Care Center of Northern VA, P.C., otherwise payable to me, for all services rendered. I am responsible to pay, but not limited to co-payments and any non-covered services. I am responsible for knowing the specifics of my insurance coverage, including limits and requirements, and will not hold the staff of Children's Health Care Center of Northern VA, P.C. responsible for any applicable insurance card(s), including those that require Children's Health Care Center of Northern VA, P.C., or Bryan W. McEachern, MD to be listed as the primary care physician, or a referral for services will be considered as self-pay. I will be responsible for these charges and filing of claims. I also authorize the physician to release any information necessary to process insurance claims. If this account is forwarded to collections, I will be responsible for all fees assessed by the attorney, agency and/or court expenses. My signature validates the information of this form for the duration of one year from today.

SIGNATURE ____ **DATE** ________________________