1123 Heatherstone Dr. • Fredericksburg, Virginia 22407 • Telephone: (540) 899-2555 • Fax: (540)899-3554
Claudia Sussdorf, M.D. • Jacinta White Topps, M.D. • Sita S. Canady, M.D. • Auri Caudill, M.D •

Patient Name: _____ Sex: Male ☐ Female ☐
Address: _____
City/County: _____ State: _____ Zip Code: _____
Date of Birth: _____ Language Preference _____
Any Allergies to Food/Medication? No ☐ Yes ☐ List: _____
Patient Phone Number (If Applicable): _____ Over 18? Yes ☐ No ☐
Patient Email:_____
Pharmacy Preference: _____ Pharmacy Phone Number: _____

Name of Parent/Guardian: _____ Date of Birth: _____
Relationship to Patient: Mother ☐ Father ☐ Legal Guardian ☐ Step-Parent ☐
Address: Same as above ☐ if different: _____
City/County: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ Secondary Number: _____
Employer's Name/Address: _____
City/County: _____ State: _____ Zip Code: _____
E-mail Address for Appointment Reminders: _____
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

---

Name of Parent/Guardian: _____ Date of Birth: _____
Relationship to Patient: Mother ☐ Father ☐ Legal Guardian ☐ Step-Parent ☐
Address: Same as above ☐ if different: _____
City/County: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ Secondary Number: _____
Employer's Name/Address: _____
City/County: _____ State: _____ Zip Code: _____
E-mail Address for Appointment Reminders: _____
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

---

Primary Insurance: _____
Policy ID: _____
Group ID: _____
Policyholder Name: _____
Policyholder SSN: _____
Policyholder DOB: _____

Secondary Insurance: _____
Policy ID: _____
Group ID: _____
Policyholder Name: _____
Policyholder SSN: _____
Policyholder DOB: _____

I understand that all financial responsibility, for any medical services provided to my child by Fall Hill Pediatrics, will be mine if it is determined that my insurance was not in effect on the date of service. I agree to pay all collection or attorney fees related to any medical services provided.

Parent/Legal Guardian/Patient Signature: _____ **Date:** _____