western michigan PEDIATRICS

REGISTRATION FORM

Child/Children **Date**_____

#1 Last_____First _____ MI __ DOB_____ Preferred Name_____ Sex at birth: M F
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: American Indian / Asian / Black / Hawaiian / White Preferred Language:

#2 Last_____ First_____ MI __ DOB_____ Preferred Name _____ Sex at birth: M F
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: American Indian / Asian / Black / Hawaiian / White Preferred Language:

#3 Last_____ First _____ MI __ DOB_____ Preferred Name _____Sex at birth: M F
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: American Indian / Asian / Black / Hawaiian / White Preferred Language:

#4 Last_____ First _____ MI __ DOB_____ Preferred Name_____ Sex at birth: M F
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: American Indian / Asian / Black / Hawaiian / White Preferred Language

Parents are: Married/ Single/ Divorced (please circle)

Appointment Reminder Preferred Contact Method Text to Cell or Phone Call Phone number _____ Whom does phone belong to?

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child/children or from obtaining information about the child's/children's medical treatment? YES or NO.

**** If yes, please explain and provide a copy of any legal paperwork that supports this restriction. _____

Parent/Guardian – Contact 1

Name: _____ Relationship to patient _____ Lives with patient: YES NO
Address _____
DOB: ___/__/_____ Cell Phone (_____) _____ email _____
Employer _____ Occupation _____ Work phone (___) _____

Parent/Guardian – Contact 2

Name: _____ Relationship to patient _____ Lives with patient: YES NO
Address _____
DOB: ___/__/_____Cell Phone (_____) _____ email _____
Employer _____ Occupation _____ Work phone (___) _____

Insurance Information

Primary Policy
Insurance Carrier:_____
Policy holders name _____
Policy holders DOB_____
ID# _____ Group # _____

Secondary Policy
Insurance Carrier: _____
Policy holders name _____
Policy holders DOB _____
ID# _____ Group # _____

Emergency Contacts
Name_____ Relationship to patient_____ Phone number (___)_____
Name_____ Relationship to patient_____ Phone number (___)_____

OVER → →

western michigan PEDIATRICS

REGISTRATION FORM

I authorize payment of medical benefits by the insured directly to Western Michigan Pediatrics. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services within 30 days unless a payment plan is negotiated in advance. I authorize Western Michigan Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

_____ _____

Parent/Guardian signature Date

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

_____ _____

Parent/Guardian signature Date

Authorization for Specific Confidential Communications

Is it ok to leave a detailed message including medical information on your voicemail? Yes ____ No ____ List Phone #:_____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than *parent/guardian*):

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care/Treatment
- ☐ Billing Information
- ☐ Appointments
- ☐ Pick up PHI (such as prescriptions, billing statements, labs, etc.)
- ☐ Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, origin of information, etc.)

_____

_____

_____

_____

This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Western Michigan Pediatrics, 721 Kenmoor Ave SE, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Parent/Guardian signature Date