



REGISTRATION FORM

| | | | | | |
|---|--|--|-----------|----------------------------|--|
| Today's Date: | | | | | |
| PATIENT INFORMATION | | | | | |
| Patient's Last name: | | First: | MI: | Date of Birth: | Sex: M or F |
| Ethnicity: Hispanic / Non-Hispanic / Unknown | | Race: American Indian / Asian / Black / Hawaiian / White | | Preferred Language: | |
| Address | | City | State | Zip | Appointment Reminder Preferred Contact Method: Phone Call Text to Cell |
| With whom does the child reside? | | | | Physician: | |
| PATIENT INFORMATION – ADDITIONAL FAMILY MEMBERS | | | | | |
| Patient's Last name: | | First: | MI: | Date of Birth: | Sex: M or F |
| Ethnicity: Hispanic / Non-Hispanic / Unknown | | Race: American Indian / Asian / Black / Hawaiian / White | | Preferred Language: | |
| With whom does the child reside? | | | | Physician: | |
| Patient's Last name: | | First: | MI: | Date of Birth: | Sex: M or F |
| Ethnicity: Hispanic / Non-Hispanic / Unknown | | Race: American Indian / Asian / Black / Hawaiian / White | | Preferred Language: | |
| With whom does the child reside? | | | | Physician: | |
| Patient's Last name: | | First: | MI: | Date of Birth: | Sex: M or F |
| Ethnicity: Hispanic / Non-Hispanic / Unknown | | Race: American Indian / Asian / Black / Hawaiian / White | | Preferred Language: | |
| With whom does the child reside? | | | | Physician: | |
| CONTACT INFORMATION | | | | | |
| Mother's/Guardian's Last Name: | | First: | MI: | Date of Birth: | Employer: |
| Address (if different than above): | | | | | |
| Home Phone: | | Cell Phone: | | Work Phone: | |
| E-Mail: | | | | | |
| Father's/Guardian's Last Name: | | First: | MI: | Date of Birth: | Employer: |
| Address (if different than above): | | | | | |
| Home Phone: | | Cell Phone: | | Work Phone: | |
| E-Mail: | | | | | |
| Emergency Contact: (Other than parents) | | | | | |
| Last Name: | | First: | Relation: | Home Phone: Cell Phone: | |
| Last Name: | | First: | Relation: | Home Phone: Cell Phone: | |
| Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES or NO | | | | | |
| ***If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____ | | | | | |
| | | | | | |
| | | | | | |

INSURANCE

(Please give your insurance card to the receptionist.)

| | | | | |
|---|----------------|--------|----------|----------------|
| Primary Insurance: Subscriber's Last Name: | | First: | MI: | Date of Birth: |
| Insurance Carrier: | Subscriber ID: | | Group #: | |
| Secondary Insurance: Subscriber's Last Name: | | First: | MI: | Date of Birth: |
| Insurance Carrier: | Subscriber ID: | | Group #: | |

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 COMMUNICATION

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 Level of Information: _____
- Billing Information
- 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, 710 Kenmoor Ave SE, Ste 110, 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

You may access all patient policies, i.e.: Copays, No Show Policy, After Hours Telephone Service, Patient-Doctor Relationship, Immunization Policy, etc. at WWW.WESTERNMICHIGANPEDIATRICS.COM

Parent/Guardian Signature _____ Date _____

Western Michigan Pediatrics, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Western Michigan Pediatrics, PC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Western Michigan Pediatrics, PC provides free language services to people whose primary language is not English.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. (616) 233-6505

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. (616) 233-6505