GRANDVILLE PEDIATRICS 2845 44TH ST. SW STE. 200, GRANDVILLE, MI 49418

PATIENT INFORMATION (PLEASE PRINT) ○ **New** ○ **Update** **Today's Date** _____

Patient's Full Name_____
Last First Mi

Date of Birth_____ ○ Male ○ Female

Home Address_____

City, State, Zip_____

Phone #_____ Preferred Method for Reminder Calls: Choose One

Please Circle ○ Phone #_____

Race: ○ American Indian or Alaska Native, ○ Asian, ○ Native Hawaiian, ○ Black or African American ○ Cell Text #_____
○ White, ○ Hispanic, ○ Other Race, ○ Other Pacific Islander, or ○ Decline to Report ○ E-mail:_____

Ethnicity: ○ Hispanic, ○ Non-Hispanic, ○ Decline to Report

PARENT INFORMATION: FATHER

Full Name_____
Last First

Date of Birth_____ Social Security #_____

Mailing Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____ Ext_____

Email Address_____

PARENT INFORMATION: MOTHER

Full Name_____
Last First

Date of Birth_____ Social Security #_____

Mailing Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____ Ext_____

Email Address_____

PLEASE LIST NAMES OF ALL STEP PARENTS

Full Name_____
Last First

Date of Birth_____ ○ Male ○ Female Relationship to Patient_____

Full Name_____
Last First

Date of Birth_____ ○ Male ○ Female Relationship to Patient_____

PLEASE LIST NAMES OF SIBLINGS

Full Name_____
Last First

Date of Birth_____ ○ Male ○ Female Relationship to Patient_____

Full Name_____
Last First

Date of Birth_____ ○ Male ○ Female Relationship to Patient_____

Full Name_____
Last First

Date of Birth_____ ○ Male ○ Female Relationship to Patient_____

Full Name_____
Last First

Date of Birth_____ ○ Male ○ Female Relationship to Patient_____

EMERGENCY CONTACT nearest Friend or Relative not living in your household

Name_____Home Phone_____

Relationship to Patient_____Work Phone_____

For New Patients: How did you hear about our office: ○ Friend ○ Family Member ○ Health Care Provider ○ Internet ○ Phonebook?

INSURANCE

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

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 ◯ NO

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

_____

_____

_____

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:

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 Officer at: Grandville Pediatrics 2845 44th St., Ste.200 Grandville, MI 49418 understand that a revocation is not effective to the extent that my physician has relied on the use of 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.

_____ _____

Patient/Parent/Guardian signature **Date**