REGISTRATION FORM

Patient's Last Name:______________________First:__________Middle:____Date of Birth:______

(Circle One) Gender: Male Female Non-Binary

Street Address:__________________________________

City: __________________________________

State/Zipcode: __________________________________

Grandville Pediatrics

CONTACT INFORMATION

PARENTAL STATUS :(CIRCLE ONE) MARRIED SEPARATED DIVORCED SINGLE

Mother's/Guardian's Last Name:___________________ First:______________Date of Birth:______

Phone Number:______________________Email:______________________________

Address (if different than above):______________________________________

Father's/Guardian's Last Name: ___________________First:______________Date of Birth:______

Phone Number:______________________Email:______________________________

Address (if different than above):______________________________________

Preferred Method for Reminder Notification (select one): Text / Email / Voicemail ( )________________

INSURANCE INFORMATION

Primary Insurance Subscriber's Name:________________________________Date of Birth:______

Subscriber's SS#______________

Insurance Carrier:________________ ID/Contract# ______________Group#______________

Secondary Insurance Subscriber's Name: ________________________________Date of Birth______

Subscriber's SS#______________

Insurance Carrier:________________ID/Contract#______________Group#:______________

I authorize payment of benefits by the insured directly to Grandville Pediatrics. I also request payment of 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 is negotiated in advance. I authorize Grandville Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

____

Patient/Guardian Signature **Date**

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATION

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.

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Patient/Guardian Signature Date

Emergency Contacts (Other than parents):

Last Name:______________________________First:___________________Relation:_________________Phone:________________

Last Name:______________________________First:___________________Relation:_________________Phone:________________

I authorize my medical provider and /or administration 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 this 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 release, etc)

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This authorization shall be in force and effective and expires 24 months or until it is revoked in writing. I understand that I have the right to revoke this authorizatio, in writing, at any time by sending a written notification to the practice at 2845 44th St, Suite 200, Grandville, MI, 49418. I understand that a revocation is not effective to the extent that my medical provider had 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.

____

Patient/Guardian Signature Date

Date Verified/Signature:____

Date Verified/Signature:____

Date Verified/Signature:____

Date Verified/Signature:____