

REGISTRATION FORM

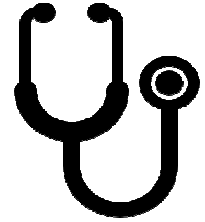
Patient's Last Name: _____ First: _____ Middle: _____ Date of Birth: _____

(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.

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)

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: _____

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