35054 23 Mile Rd., Suite 101
New Baltimore, MI 48047
(586) 725-2670

25650 Kelly Rd., Suite 13
Roseville, MI 48066
(586) 774-7710

Electronic Medical Record
Patient Registration Form

Patient Information

Child's Last Name	Child's First Name	M.I.	Sex (circle)		Birthdate (MM/DD/YYYY)
			M	F	

Home Address: _____ Home Phone: (_____) _____
Street Address City State Zip

Full name(s) of sibling(s): _____

Person financially responsible for child/children: _____

Who should receive billing statements? _____

Patient's Ethnicity (please check)
___ Hispanic or Latino
___ Non-Hispanic or Latino
___ Unknown
___ Not applicable

Patient's Race (please check)
___ Asian
___ Black or African American
___ Hawaiian Native or Pacific Islander
___ American Indian or Alaskan Native
___ White
___ Unknown

Parent/Guardian Information

Full Name: _____

Birthdate: _____/_____/_____

Relation to Patient(s): _____

Home Address _____
(if different from patient's) _____

Cell #: (____) _____ Work #: (____) _____

Preferred E-Mail: _____

Employer: _____

Parent/Guardian Information

Full Name: _____

Birthdate: _____/_____/_____

Relation to Patient(s): _____

Home Address _____
(if different from patient's) _____

Cell #: (____) _____ Work #: (____) _____

Preferred E-Mail: _____

Employer: _____

Insurance Information – Primary Plan

Plan Name: _____ Effective Date: _____

Subscriber: _____

Policy/Contract #: _____

Insurance Information – Secondary Plan

Plan Name: _____ Effective Date: _____

Subscriber: _____

Policy/Contract #: _____

Please continue on back side →

Emergency Contact(s)

In the event of an emergency, whom should we contact?

1. Full Name: _____ Relation: _____

   Phone Number: (_____) _____ This phone number is a…(circle one): Home # Cell # Work #

2. Full Name: _____ Relation: _____

   Phone Number: (_____) _____ This phone number is a…(circle one): Home # Cell # Work #

Preferred Pharmacy

Name of Pharmacy: _____

Pharmacy Phone #: (_____) _____

Pharmacy Address: _____
Street Address City State ZIP

Release and Assignment

To the best of my knowledge, the information that I have written on this document is correct. I understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform Pediatric Clinic, P.C. of any changes in my child's/minor's medical status, residential status, insurance information, and contact information.

I certify that my child/minor is covered by insurance with _____ and assign all insurance benefits directly to Pediatric Clinic, P.C. I understand that I am financially responsible for all charges whether or not they are paid by insurance, including, but not limited to, co-pays and deductibles.
Name(s) of Insurance Company/Companies

I hereby authorize Pediatric Clinic, P.C. to release all information necessary to secure the payment of benefits.

I authorize the use of this signature of all of my insurance submissions whether manual or electronic.

SIGN HERE

Signature of Parent/Guardian: _____ Date: _____

Acknowledgment of Receipt of "Notice of Privacy Practices"

By signing below, I acknowledge that I have received a copy of Pediatric Clinic P.C.'s "Notice of Privacy Practices" form.

SIGN HERE

Parent/Guardian Signature: _____ Date: _____

Witness(es): _____

Whom may we thank for referring you? _____

NO-SHOW POLICY

If you must reschedule your child's visit, please call to notify our office at least 24 hours in advance during regular business hours. Continued failure to notify our staff of any sudden scheduling conflicts may result in dismissal from the practice.