PLEASE PRINT CLEARLY Today's Date: ___________________________

Please list the names / info for each child individually

______________________ ______________ ________ ____________
LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

Gender: __________________ **Ethnicity:** ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline to Specify ☐ Unknown

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify ☐ Unknown

______________________ ______________ ________ ____________
LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

Gender: __________________ **Ethnicity:** ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline to Specify ☐ Unknown

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify ☐ Unknown

______________________ ______________ ________ ____________
LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

Gender: __________________ **Ethnicity:** ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline to Specify ☐ Unknown

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify ☐ Unknown

______________________ ______________ ________ ____________
LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

Gender: __________________ **Ethnicity:** ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline to Specify ☐ Unknown

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify ☐ Unknown

______________________ ______________ ________ ____________
LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

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Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify ☐ Unknown

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LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

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Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify ☐ Unknown

It is important that we know all persons involved in your child's care. We need to know: who carries insurance on the children, if there are multiple insurance policies, which one is primary and which one is secondary. Please fill in each parent section below. Tell us whom we should contact for reminder calls or other pertinent patient information by checking **[√] primary** on **one** of the parent's phone numbers. ***Communication Policy***: LPA will communicate with the parents/guardians who schedule the appointment, attend an appointment, or calls the medical advice hotline. It is the *parent/guardian's* duty to inform absent parents/guardians of the treatment, status or follow up information regarding the child. LPA has no obligation to inform absent parents/guardians of treatment, status or follow up information regarding the child. With the proper authorization, LPA shall release treatment, status or follow up information to a parent or guardian who contacts LPA.

☐ Parent/Father/Mother
☐ Guardian/Other ____
Last Name First Name

____
Street Address

____
City State Zip County

________________________ ______________
Social Security Number Date of Birth

Cell Phone [ ] **primary** Work Phone [ ] **primary** Home Phone [ ] **primary**

____
Email address

____
Employed by Occupation

____
Medical Insurance and Subscriber

☐ Parent/Mother/Father
☐ Guardian/Other ____
Last Name First Name

____
Street Address

____
City State Zip County

________________________ ______________
Social Security Number Date of Birth

Cell Phone [ ] **primary** Work Phone [ ] **primary** Home Phone [ ] **primary**

____
Email Address

____
Employed by Occupation

____
Medical Insurance and Subscriber

OVER →

Children Reside With: ☐ Father ☐ Mother ☐ Both ☐ Other:_____

☐ Stepparent
☐ Guardian/Other _____
Last Name First Name

_____
Street Address

_____
City State Zip County

_____ _____
Social Security Number Date of Birth

_____ _____ _____
Home Phone[ ] **primary** Work Phone [ ] **primary** Cell Phone [ ] **primary**

_____
Employed by Occupation

_____

☐ Stepparent
☐ Guardian/Other _____
Last Name First Name

_____
Street Address

_____
City State Zip County

_____ _____
Social Security Number Date of Birth

_____ _____ _____
Home Phone [ ] **primary** Work Phone [ ] **primary** Cell Phone [ ] **primary**

_____
Employed by Occupation

_____

Please list any person(s) **authorized to seek medical treatment, information, or advice** pertaining to your child/children:

Name	Relationship
_____	_____
_____	_____
_____	_____

Do Children have: Medicaid Services - Yes ☐ No ☐ Children's Special Health Care Services - Yes ☐ No ☐

_____

In the event of an emergency (weather or safety related) that our office must temporarily interrupt business to seek shelter, you have the option of leaving, but agree to hold LPA harmless of any injury/issue that may occur related to your departure.

☐ I agree

Person we may call if unable to reach you for NON medical and medical information:

Name	Relationship	Phone
_____	_____	_____

Previous Physician: _____ Referred by: _____

FULL PAYMENT IS EXPECTED AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. A fee will be assessed for any insufficient checks returned from the bank and/or retracted credit card payments. The information I have given is correct to the best of my knowledge, and I understand it is my Responsibility to inform this office of any changes in my child's medical or insurance status. I authorized Lansing Pediatric Associates, P.C. to release all information necessary to secure payment and/or authorization info from my/our insurance company. I also understand LPA orders tests based on medical indication, not insurance benefits and it is my responsibility to determine insurance coverage. I also authorize the exchange of information with specialists involved in my/our child's health care. I understand that the information I have given is correct to the best of my knowledge.

Signature of Parent or Guardian _____ Date _____

PLEASE CIRCLE YOUR PRIMARY CARE PHYSICIAN:

Dr. Amendt **Dr. Chapin** **Dr. Hult** **Dr. Klein** **Dr. Lewandowski** **Dr. Loznak** **Dr. Josh** **Dr. Vanderstelt** **Dr. Acre**