PLEASE PRINT

Patient Information

Today's Date: _____

Name of Person Completing Form: _____ Relationship: _____

Child's Personal Information:

Child's Name_____ Previous Name: _____

Date of Birth _____Sex: M or F Birth Order: _____ SSN: _____

Race: _____ Ethnicity: _____ Language: _____

Place of Birth: _____ Hospital Name: _____

Address where Child Resides:

Street: _____City:_____ State: _____Zip_____

Biological Parent Information

	Parent (mother)	Parent (father)
Full Name	_____	_____
Date of Birth	_____	_____
Address	_____	_____
City/State/Zip	_____	_____
Home Phone	_____	_____
Cell Phone	_____	_____
Employer	_____	_____
Occupation	_____	_____
Work Phone	_____	_____

Parent's Marital Status: Married Separated Divorced Unmarried Widowed

Step Parent or Foster Parent Information (please provide letter of guardian ship)

	Parent	Parent
Full Name	_____	_____
Address	_____	_____
City/State/Zip	_____	_____
Home Phone	_____	_____
Cell Phone	_____	_____
Employer	_____	_____
Occupation	_____	_____
Work Phone	_____	_____

PLEASE PRINT

Medical Insurance

PLEASE PRESENT A COPY OF YOUR MOST RECENT INSURANCE CARD

	Primary	Secondary
Insurance Co	_____	_____
Policy Holder Name	_____	_____
Date of Birth	_____	_____
Social Security #	_____	_____
Group Number	_____	_____
Policy/Member ID #	_____	_____
Policy Start Date	_____	_____
Copay $$$	_____	_____

Be sure to report any changes in Address, Marital Status and Insurance coverage to your primary and secondary insurance. Michigan Insurance Law is regulated by the "Birth Day Rule". Which means: the member whose birthday comes first in the year is primary. Unless there is a divorce settlement which mandates who is to carry the primary insurance.

Emergency Contact or Relative to Parents

Name _____

Address _____

City/State/Zip _____

Home Phone _____

Cell Phone _____

Relationship to Patient _____

Siblings

_____ Date of Birth _____ Relationship _____

_____ Date of Birth _____ Relationship _____

_____ Date of Birth _____ Relationship _____

_____ Date of Birth _____ Relationship _____

PLEASE PRINT

OFFICE POLICY OVERVIEW

The providers and staff of Southside Pediatrics are honored to be a part of your child's future. As your **Medical Home Provider** we look forward to building a relationship with you, your child and your family. So that we can better serve the needs of your child please be sure to keep us up-to-date with any changes in: Health Condition, Contact Information, and Insurance Status.

In accordance with federal and state protected health information and privacy laws, as well as state medical retention laws, Southside Pediatrics is committed to maintaining your child's medical record in a secured environment. Your child's medical record will be maintained in a written and electronic form at this location or in an alternate off site storage location retained by Southside Pediatrics PC. We will request that you clearly identify those family members who you wish to have medical information disclosed to, other than the Biological parents of the child.

If you are unable to accompany your child to his/her appointment and need to send someone in your place, Southside Pediatrics requests that you provide the office with either a written permission slip acknowledging the name of the person bringing your child and that you give them permission to make medical decisions in your absence. If this is not possible, please call us prior to the appointment time and give us verbal permission.

We understand that unforeseen circumstances/emergencies occur that may affect your ability to keep your appointment. We ask that you notify the office prior to your appointment time, as soon as possible. Multiple missed appointments are subject to Discharge from the practice. So please call us as soon as you can, this will give us an opportunity to reschedule your appointment and provide an appointment time for another child who needs to be seen.

Most insurance plans do not pay all medical services, even those services that might be helpful to the patient. When the service is not covered by your insurance policy or there is a co-pay, deductible or co-insurance, you will be responsible for the balance. Co-Pays are due at the time of service unless other financial arrangements have been made with the office. Unpaid, overdue balances are subject to collection proceeding so please contact the office if you are having financial difficulties.

Vaccine Administration Office Policy: parents choosing to not vaccinate their child will be required to document their choice by signing Southside Pediatrics approved *"Refusal to Consent to Vaccinate*" form. If the parent/guardian/patient is unwilling to sign the refusal form, the providers of Southside Pediatrics will be forced to separate their relationship with the family. While you are seeking a new primary care provider, Southside Pediatrics will extend 30 days of emergency services only. A copy of your child's medical record will be forwarded to your new primary care within 30 days after receiving a signed HIPPA compliant medical records request form.

Parental Acknowledgement

The information I have provided to Southside Pediatrics is accurate and truthful. I have read and understand the policies set forth by Southside Pediatrics. I recognize and accept full responsibility for payment of all services rendered by Southside Pediatrics. I authorize the release of any information necessary to the insurance company to process medical claims and request that any payment of medical benefits is made directly to Southside Pediatrics. I understand that I must make a request in writing to my physician in advance of the appointment, if there are any insurance claims that I require NOT TO BE submitted to my insurance company. I understand my financial responsibilities regarding any balance that may be left non-paid by my insurance policy.

Please Print Your Name here: _____

Please Sign and date here:_____

Consent for Treatment

I authorize Southside Pediatrics, through its appropriate personnel, to perform the appropriate assessment and treatment procedures upon my child/legal dependent, as the provider deems medically necessary.

_____

Patient's Name, Date of Birth

_____

Signature of parent or legal guardian, Today's Date