Pediatric Surgeons of West Michigan, P.C.

Robert H. Connors, M.D. | Marc G. Schlatter, M.D. | Neal D. Uitvlugt, M.D. | James M. DeCou, M.D. | Daniel J. Robertson, M.D. | Emily T. Durkin, M.D.

YOUR CHILD

Full legal name _____

Nickname_____Sex_____

Birthdate_____Age_____

Home Address_____

City/State/Zip_____

Child's Social Security #_____

Telephone # ( )_____

MOTHER or _____ Guardian _____ Stepmother

Name_____DOB_____

Home #_____

Cell #_____

Work #_____

Employer_____

Address (if different) _____

FATHER or _____ Guardian _____ Stepfather

Name_____DOB_____

Home #_____

Cell #_____

Work #_____

Employer_____

Address (if different)_____

Are you the legal guardian for the patient? Yes No

If no, do you have written authorization from guardian for us to see &/or treat the patient? _____

Do you speak English Yes No

If no, what language do you speak? _____

PEDIATRICIAN OR FAMILY DOCTOR

Name_____MD or DO

Practice Name_____

City_____Phone #_____

EMERGENCY CONTACT (other than the parents)

Name(s)_____

Relationship to patient_____

Home # _____

Work # _____

INSURANCE COVERAGE

Primary Insurance Name_____

Subscriber's Full Name_____

Relationship to patient_____

Subscriber's SS #_____DOB_____

Give us your card to copy

Secondary Insurance Name:_____

Subscriber's Full Name_____

Relationship to patient_____

Subscribers SS #_____DOB_____

Give us your card to copy

Other insurance information pertinent to your child_____

_____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer:

_____Cash

_____Personal check

_____Credit Card _____Visa _____MC

_____ I wish to discuss the office's payment policy.

AUTHORIZATION AND RELEASE (Please read the following and sign below)

All professional services rendered to the patient are charged to the above indicated responsible parent. Necessary forms will be completed to help expedite insurance carrier payments, however, the parent is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. With my signature, I authorize Pediatric Surgeons of West Michigan, P.C., to furnish &/or receive information to or from any referral physician, facility or insurance carrier concerning the patient's illness and/or treatment. I hereby assign to the physician all payments for medical services rendered to the patient. I understand that I am responsible for any amount not covered by insurance.

DATE: _____SIGNATURE_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

WITNESSES:

_____ _____

Parent/Guardian Signature

_____ _____

Date

Documentation of Failure to Obtain Signed Acknowledgment

On _____, 20 , _____ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to _____ (the "Patient"). The Patient refused to provide a signature when requested.

Whom may we discuss your child's care with?

Mother _____ Father _____ Other _____ Name: _____

Can we call your home phone number regarding your child's care? Yes ____ No ____

What information may we leave on your answering machine or voice mail?

Nothing _____ Everything _____ Other _____

Appointment reminder _____ Surgery information _____ Prescription information _____