

# 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.

## PATIENT

Full legal name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Home Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Telephone Home (        ) \_\_\_\_\_  
Cell (        ) \_\_\_\_\_  
Work (        ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Employer \_\_\_\_\_  
Last Menstrual Period \_\_\_\_\_  
Name of Baby's Father \_\_\_\_\_  
Husband's Name \_\_\_\_\_  
Address (if different) \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Telephone Cell (        ) \_\_\_\_\_  
Employer \_\_\_\_\_ Wk#(        ) \_\_\_\_\_

## EMERGENCY CONTACT

Name(s) \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Home#(        ) \_\_\_\_\_ Wk#(        ) \_\_\_\_\_  
Do you speak English? [  ] Yes [  ] No  
If no, what language do you speak? \_\_\_\_\_

## OBSTETRICIAN SPECIALIST OR REFERRAL DOCTOR

Name \_\_\_\_\_ MD or DO  
Practice Name \_\_\_\_\_  
City \_\_\_\_\_ Phone#(        ) \_\_\_\_\_

## FAMILY DOCTOR OR OBSTETRICIAN

Name \_\_\_\_\_ MD or DO  
Practice Name \_\_\_\_\_  
City \_\_\_\_\_ Phone#(        ) \_\_\_\_\_

## INSURANCE COVERAGE

Primary Insurance Name \_\_\_\_\_  
Subscriber's Full Name \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ SS# \_\_\_\_\_  
Secondary Insurance Name \_\_\_\_\_  
Subscriber's Full Name \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ SS# \_\_\_\_\_

Will your baby be covered by the same insurance  
as you? \_\_\_\_\_ Yes \_\_\_\_\_ No

Baby's Insurance Name \_\_\_\_\_  
Subscriber's Full Name \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ SS# \_\_\_\_\_

## 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.

<p>Whom may we discuss your child's care with?</p> <p>Mother _____ Father _____ Other _____ Name: _____</p> <p>Can we call your home phone number regarding your child's care? Yes ___ No ___</p> <p>What information may we leave on your answering machine or voice mail?</p> <p>Nothing _____ Everything _____ Other _____</p> <p>Appointment reminder _____ Surgery information _____ Prescription information _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------