Pediatric Surgeons of West Michigan, P.C.

Marc G. Schlatter, M.D. | James M. DeCou, M.D. | Emily T. Durkin, M.D. | Daniel J. Watkins, M.D. | Elliot C. Pennington, M.D. | Eric M. Groh, M.D

PATIENT

Full legal name _____

Birth date_____ Age _____

Home Address _____

City/State/Zip _____

Social Security # _____

Home Telephone ( ) _____

Cell ( ) _____

Work ( )_____ Ext. _____

Employer_____

Last Menstrual Period _____

Name of Baby's Father _____

Home Address (if different) _____

City/State/Zip _____

Telephone Cell ( ) _____

Employer_____ Wk#( ) _____

EMERGENCY CONTACT

Name(s) _____

Relationship to patient _____

Home#( )_____ Cell# ( ) _____

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

ALL CO-PAYS ARE DUE AT TIME OF SERVICE.

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

_____Cash

_____Personal check

_____Credit Card

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

AUTHORIZATION AND RELEASE, PAYMENT AGREEMENT (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.

_____ _____

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.