

PATIENT REGISTRATION FORM

ORCHARD PEDIATRICS
6900 ORCHARD LAKE ROAD, SUITE 206
WEST BLOOMFIELD, MI 48322

2010

FAMILY NAME _____

CHART NUMBER _____

FATHER'S NAME _____ BIRTHDATE _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOME PHONE () _____ WORK PHONE () _____ CELL PHONE () _____ EMAIL ADDRESS _____ SOCIAL SECURITY # _____ EMPLOYER _____ INSURANCE COMPANY _____ INSURANCE POLICY # _____	MOTHER'S NAME _____ BIRTHDATE _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOME PHONE () _____ WORK PHONE () _____ CELL PHONE () _____ EMAIL ADDRESS _____ SOCIAL SECURITY # _____ EMPLOYER _____ INSURANCE COMPANY _____ INSURANCE POLICY # _____
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I DO / DO NOT (PLEASE CIRCLE ONE) GIVE PERMISSION TO LEAVE BASIC INFORMATION ON MY PERSONAL VOICE MAIL.

LIST THE LEGAL NAME OF ALL CHILDREN THAT ARE PATIENTS IN THIS OFFICE (INCLUDE LAST NAME IF DIFFERENT FROM ABOVE)

<u>NAME</u>	<u>BIRTHDATE</u>	<u>MALE / FEMALE</u>	<u>SOCIAL SECURITY #</u>

HAVE THERE BEEN ANY CHANGES IN YOUR CHILDREN'S PERSONAL OR FAMILY HEALTH HISTORY YES NO IF YES, PLEASE REQUEST A HEALTH HISTORY FORM

WHICH INSURANCE POLICY ARE THE CHILDREN ON? _____ IF BOTH, WHICH IS THE PRIMARY POLICY? _____

IF MOTHER AND FATHER HAVE DIFFERENT ADDRESSES, WHERE DO THE CHILDREN LIVE? _____

EMERGENCY CONTACT PERSON (SOMEONE NOT LIVING IN YOUR HOME) NAME: _____

TELEPHONE # () _____

PLEASE READ AND SIGN

I, _____ THE MOTHER / FATHER OF (LIST ALL CHILDREN) _____

1. I GIVE ORCHARD PEDIATRICS, P.C. PERMISSION TO TREAT MY CHILDREN SHOULD ANY OR ALL OF THEM PRESENT TO YOUR OFFICE WHEN NOT ACCOMPANIED BY A PARENT. THIS CONSENT SHALL BE VOID UPON WRITTEN REQUEST.
2. PERMISSION IS GRANTED TO ORCHARD PEDIATRICS, P.C., TO RELEASE REQUESTED INFORMATION TO MY INSURANCE COMPANY FOR BILLING PURPOSES OR PATIENT-CENTERED MEDICAL HOME (PCMH) WELLCENTIVE PATIENT REGISTRY.
3. I AUTHORIZE PAYMENT FOR MEDICAL SERVICES BY MY INSURANCE COMPANY TO ORCHARD PEDIATRICS, P.C.
4. IF MY CHILD'S INSURANCE CARRIER DENIES PAYMENT OF SERVICES, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

SIGNATURE _____ DATE _____ OFFICE WITNESS _____ DATE _____