

PATIENT REGISTRATION FORM

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

2012

FAMILY NAME _____

ACCT# _____

FATHER'S NAME	MOTHER'S NAME
BIRTHDATE	BIRTHDATE
ADDRESS	ADDRESS
CITY	CITY
STATE	STATE
ZIP	ZIP
HOME PHONE ()	HOME PHONE ()
CELL PHONE ()	CELL PHONE ()
WORK PHONE ()	WORK PHONE ()
PREFERRED METHOD OF TELEPHONE CONTACT:	PREFERRED METHOD OF TELEPHONE CONTACT:
EMAIL ADDRESS	EMAIL ADDRESS
SOCIAL SECURITY #	SOCIAL SECURITY #
EMPLOYER	EMPLOYER
INSURANCE COMPANY	INSURANCE COMPANY
POLICY#	POLICY #

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)

NAME	BIRTHDATE	MALE / FEMALE

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 _____