Traverse Area Pediatric and Adolescent Clinic

If all children are on a family plan, space is provided below in the Family Insurance Information section of this form.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Child 1

Last Name _____ **First Name** _____ **MI** _____ **Date of Birth** _____

Primary Language _____ **Sex** Female / Male

Race Asian / African-American / Hawaiian / Caucasian / Native American **Ethnicity** Hispanic / Non-Hispanic / Unknown

Individual Insurance Plan _____ **Plan ID#** _____

Child 2

Last Name _____ **First Name** _____ **MI** _____ **Date of Birth** _____

Primary Language _____ **Sex** Female / Male

Race Asian / African-American / Hawaiian / Caucasian / Native American **Ethnicity** Hispanic / Non-Hispanic / Unknown

Individual Insurance Plan _____ **Plan ID#** _____

Child 3

Last Name _____ **First Name** _____ **MI** _____ **Date of Birth** _____

Primary Language _____ **Sex** Female / Male

Race Asian / African-American / Hawaiian / Caucasian / Native American **Ethnicity** Hispanic / Non-Hispanic / Unknown

Individual Insurance Plan _____ **Plan ID#** _____

Child 4

Last Name _____ **First Name** _____ **MI** _____ **Date of Birth** _____

Primary Language _____ **Sex** Female / Male

Race Asian / African-American / Hawaiian / Caucasian / Native American **Ethnicity** Hispanic / Non-Hispanic / Unknown

Individual Insurance Plan _____ **Plan ID#** _____

Circle One

MOM / DAD / STEP-MOM / STEP-DAD / GUARDIAN / OTHER _____

Name _____ Lives with patient? **YES / NO** Date of Birth _____

Address _____

City _____ State & Zip _____

Home Phone _____ Cell Phone _____ Email _____

Circle One

MOM / DAD / STEP-MOM / STEP-DAD / GUARDIAN / OTHER _____

Name _____ Lives with patient? **YES / NO** Date of Birth _____

Address _____

City _____ State & Zip _____

Home Phone _____ Cell Phone _____ Email _____

Family Insurance Information

Primary Insurance _____	**Secondary Insurance** _____
Group # _____	Group # _____
Member ID _____	Member ID _____
Subscriber _____	Subscriber _____
Subscriber DOB _____	Subscriber DOB _____

Traverse Area Pediatric and Adolescent Clinic

How would you ideally prefer to be contacted regarding (circle one)

Medical Issues	Home Phone / Work Phone / Cell Phone / Home Email
Appointment Reminders	Home Email / Work Email / Text / Other Contact Method
Billing Statements	Home Address / Home Email / Work Email
General Practice Notices	Home Address / Home Phone / Cell Phone / Home Email
Patient Portal Notifications	Home Email / Work Email / Cell Phone

Additional Contact Questions

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? _____

If parents are divorced, separated or live separately please fill out this section

Who has custody?

Are there legal restrictions that would restrict non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **YES / NO**

If yes, please explain and provide a copy of any legal paperwork that supports that restriction _____

We cannot discuss a patient's care with anyone that is not listed on the patient's account. This includes any step-parents.

lf anyone other than biological parents will seek care for the patient an Authorization to Treat Form signed by a parent must be on file. This includes step parents.

If there are Step-Parents or Additional Parents please list them below

Circle One

MOM / DAD / STEP-MOM / STEP-DAD / GUARDIAN / OTHER _____

Name _____ Lives with patient? **Yes / No** Date of Birth _____

Address _____ _____

City _____ State & Zip _____

Relationship _____ Email _____

Home Phone _____ Cell Phone _____

Circle One

MOM / DAD / STEP-MOM / STEP-DAD / GUARDIAN / OTHER _____

Name _____ Lives with patient? **Yes / No** Date of Birth _____

Address _____ _____

City _____ State & Zip _____

Relationship _____ Email _____

Home Phone _____ Cell Phone _____

Emergency contact(s) other than parents

Name / Relationship _____ **Phone** _____

Name / Relationship _____ **Phone** _____

Our physicians believe in the standards of care recommended by the American Academy of Pediatricians and follow these standards in providing care to you. We cannot know whether your insurance carrier supports every service provided, therefore, you may be responsible for payment for denied services.

I understand that when I chose to use the Patient Portal for my record I will not use it for emergency or urgent communication with the office.

_____ _____

Patient / Guardian Signature Date

_____

Printed Name of Signee