



REGISTRATION FORM

Today's Date:					
PATIENT INFORMATION					
Patient's Last name:		First:	MI:	Date of Birth: Age:	Sex: M or F
Preferred Name:		Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown		Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
Address		City	State	Zip	Reminder Call: CALL or TEXT (please select one) Primary Phone: Secondary Phone:
With whom does the child reside?				Physician:	
SIBLING INFORMATION					
Patient's Last name:		First:	MI:	Date of Birth: Age:	Sex: M or F
Preferred Name:		Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown		Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside?				Physician:	
Patient's Last name:		First:	MI:	Date of Birth: Age:	Sex: M or F
Preferred Name:		Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown		Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside?				Physician:	
Patient's Last name:		First:	MI:	Date of Birth: Age:	Sex: M or F
Preferred Name:		Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown		Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside?				Physician:	
Patient's Last name:		First:	MI:	Date of Birth: Age:	Sex: M or F
Preferred Name:		Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown		Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside?				Physician:	
CONTACT INFORMATION					
Parent # 1 Last Name:		First:	MI:	Date of Birth:	Employer:
Address (if different than above):					
Home Phone:		Cell Phone:		Work Phone:	
E-Mail:					
Parent # 2 Last Name:		First:	MI:	Date of Birth:	Employer:
Address (if different than above):					
Home Phone:		Cell Phone:		Work Phone:	
E-Mail:					

Emergency Contact: (Other than parents)

Last Name:	First:	Relation:	Home Phone:
			Cell Phone:
Last Name:	First:	Relation:	Home Phone:
			Cell Phone:

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES or NO
***If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____

INSURANCE

(Please give your insurance card to the receptionist.)

Primary Insurance: Subscriber's Last Name:	First:	MI:	Date of Birth:
Insurance Carrier:	Subscriber ID:		Group #:
Secondary Insurance: Subscriber's Last Name:	First:	MI:	Date of Birth:
Insurance Carrier:	Subscriber ID:		Group #:

I authorize payment of medical benefits by the insured directly to Cascade Pediatrics. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services within 30 days unless a payment plan is negotiated in advance. I authorize Cascade Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Patient/Guardian signature Date

INSURANCE

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

Patient/Guardian signature Date

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATION

Is it ok to leave a detailed message including medical information on your voicemail? Yes ___ No ___ List Phone #: _____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than *parent/guardian*):

Name: _____	Relationship to Patient: _____
Name: _____	Relationship to Patient: _____
Name: _____	Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- Medical Care/Treatment Level of Information: _____
- Billing Information
- Pick up PHI (such as prescriptions, billing statements, labs, etc.)
- Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, origin of information, etc.)

This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Cascade Pediatrics 5150 Cascade Rd SE, Suite B, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian signature Date