

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

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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.

If 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, Address, City, Relationship, Home Phone, Lives with patient?, Date of Birth, State & Zip, Email, Cell Phone

Circle One

MOM / DAD / STEP-MOM / STEP-DAD / GUARDIAN / OTHER
Name, Address, City, Relationship, Home Phone, Lives with patient?, Date of Birth, State & Zip, Email, 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