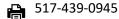
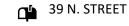


Patient Information

517-437-5385





HILLSDALE MI, 49242

Race and Ethnicity are needed for state Immunization Record

Patient Name:		Race:
Guardian 1:	Relationsl	hip:
Lives with patient? Y N Social	Security #:	Date of Birth:
Home Address:	Cell Phone #	
CitySt	Zip	
Employer:	Employee	e Phone #
Guardian 2:	Relationsl	hip:
Lives with patient? Y N Social	Security #:	Date of Birth:
Home Address:	Cell Phone #	
CitySt		
Employer:	Employee Phone #	
Name and address for who should i	receive billing statem	ents:
Emergency Contact:		Cell Phone #:
Someon	e who we can call if p	parents are unreachable!)
Date of Birth:	Gender:	PLEASE CIRCLE: Hispanic or Non-Hispanic
If parents are divorced or separated,	, complete:	
Who has custody?	Are	there legal restrictions preventing non-custodial
	eatment for the patie	nt or obtaining patient's medical treatment? \mathbf{Y} \mathbf{N} . If

Authorization for Medical Care

I authorize the following people to bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence. This does **NOT** allow them to have access to confidential health information that is not relevant for the visit. Name: _____ Relationship: _____ Relationship: I understand telephone triage and advice services will be extended to the above persons if regarding direct patient care while the child is in their care. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If we cannot reach you, we will not refuse treatment. This serves as consent for medical treatment we deem as medically necessary and appropriate. Parent /Guardian Signature ______ Date _____ Relationship ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE By signing below, I acknowledge that I have been offered Nichole K. Ellis, D.O.'s Notice of **Privacy Practices ("Notice")** I have been given an opportunity to read the practice's HIPPA Notice of Privacy Practices and I am entitled to a personal copy if I ask for one. I understand that this authorization will not expire until I revoke this by notifying the above office in writing. MEDICAL INFORMATION RELEASE FORM [] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to: [] MOM _____ [] OTHER _____ (ex: grandparents, sitter, step parent, athletic dept) [] INFORMATION IS NOT TO BE RELEASED TO ANYONE. This **Release of Information** will remain in effect until terminated by me in writing. This release also authorizes any medical records or other information needed to process claims for payment. **MESSAGES**: If unable to reach me: [] you may leave a detailed message [] please leave a message asking me to return your call Signed: Date:

Witness: _____ Date: _____