Patient Information

THE PEDIATRIC PLACE OF HILLSDALE

517-437-5385
517-439-0945
39 N. STREET
HILLSDALE MI, 49242

****Race and Ethnicity are needed for state Immunization Record****

Patient Name: _____ **Race:** _____

Guardian 1: _____ **Relationship:** _____

Lives with patient? Y N Social Security #: _____ **Date of Birth:** _____

Home Address: _____ Cell Phone #_____
City_____ St_____ Zip_____

Employer: _____ Employee Phone #_____

Guardian 2: _____ **Relationship:** _____

Lives with patient? Y N Social Security #: _____ **Date of Birth:** _____

Home Address: _____ Cell Phone #_____
City_____ St_____ Zip_____

Employer: _____ Employee Phone #_____

Name and address for who should receive billing statements:

_____

Emergency Contact: _____Cell Phone #: _____

(Someone who we can call if 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 parent from consenting to medical treatment for the patient or obtaining patient's medical treatment? **Y N.** If yes, please explain and provide a copy of legal paperwork supporting this restriction:

_____

_____

_____

PLEASE COMPLETE BACK OF PAGE

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: _____

Name: _____ 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 _____

[] DAD _____

[] 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: _____