ARBOR MEDICAL
PARTNERS

Date _____
Chart # _____

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

PREFERRED NAME: _____ SEX: _____ AGE: _____

ADDRESS: _____

CELL # FOR APPOINTMENT CONFIRMATIONS: _____

PREFERRED LANGUAGE: _____ RACE/ETHNICITY: _____

SIBLINGS AT PRACTICE: _____

PARENT INFORMATION

PARENT NAME: _____ RELATION TO CHILD: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____ EMAIL: _____

_____ SS #: _____

PARENT NAME: _____ RELATION TO CHILD: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____ EMAIL: _____

_____ SS #: _____

STEPMOM: _____ STEPDAD: _____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

PHONE #: _____ PHONE #: _____

****This form does not give consent for stepparents to bring children into the office. Please ask the front office for a "Consent to Treat" form to keep on file.****

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

PRIMARY INSURED: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP NUMBER: _____

SECONDARY INSURANCE CARRIER: _____

PRIMARY INSURED: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP NUMBER: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby certify that the information provided here is true and correct. I authorize Arbor Medical Partners to release information to my insurance company for the processing of medical claims. I assign insurance benefits to Arbor Medical Partners for all medical services performed. I understand that insurance benefits are determined by the contract I hold with my insurance company, and that I am responsible for all fees not paid by insurance as stated in my policy. I also hereby certify that the person signing the form will be listed as the Responsible Party (Guarantor) of the Child (ren) accounts. This is who all statements will be sent to.

_____ _____

Parent/Legal Guardian Signature Date