



5082 Lovers Lane Portage, Michigan 49002 (P) 269-381-0118 (F) 269-381-4610

Patient Demographics

Name of Children	DOB	Sex	Preferred Name	Pronounced As	Child's Cell #
1.					
2.					
3.					
4.					
5.					

Is there a court order for any of your children regarding legal, financial, or physical custody? Yes ___ No ___
 Does child/children live with both parents? Y/N If not, who is the legal guardian? _____

Parent Information

Parent/Guardian #1:	Parent/Guardian #2:
Name of Spouse:	Name of Spouse:
Relationship to Patient:	Relationship to Patient:
Address:	Address:
City: State: Zip:	City: State: Zip:
Cell phone: DOB:	Cell phone: DOB:
Home phone:	Home phone:
Email address:	Email address:
Is this child's primary address:	Is this child's primary address:

Insurance Information

Subscriber's Name	Sub DOB	Rel. to Child	Insurance Co Name	Contract, Policy or ID #	Group #	Co-Pay
1.						\$
2.						\$

Emergency Contact Other Than Parent:

Name _____ Phone _____ Relationship to Patient _____

Name of Person (s) That You Authorize To Obtain Medical Care for Your Children:

Medical care may include; immunizations, in office procedures and injections when needed in the event a parent cannot bring the child to the appointment.

Name	Relationship to Child	Phone #

If you wish to give your older child permission to bring them self, please read and initial below:

_____ Trestlewood Pediatrics, P.C., has my permission to treat my child for wellness with possible immunizations and illnesses, as they are able to bring themselves to the appointment.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby assign to Trestlewood Pediatrics, P.C., all payments for medical benefits rendered to the patients listed on this form. I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

Date Reviewed	Initial	Date Reviewed	Initial	Date Reviewed	Initial