Pediatric Surgeons of West Michigan, P.C.

Robert H. Connors, M.D. | Marc G. Schlatter, M.D. | Neal D. Uitvlugt, M.D. | James M. DeCou, M.D. | Emily T. Durkin, M.D. | John G. Schneider, M.D. | Daniel J. Watkins, M.D.

PATIENT

Full legal name ______________________

Birth date______________________ Age __________

Home Address ______________________

City/State/Zip ______________________

Social Security # ______________________

Home Telephone ( ) ______________________

Cell ( ) ______________________

Work ( ) ______________________ Ext. __________

Employer ______________________

Last Menstrual Period ______________________

Name of Baby's Father ______________________

Home Address (if different) ______________________

City/State/Zip ______________________

Telephone Cell ( ) ______________________

Employer______________ Wk#( ) ______________

EMERGENCY CONTACT

Name(s) ______________________

Relationship to patient ______________________

Home#( )______________ Cell# ( ) ______________

Do you speak English? [ ] Yes [ ] No

If no, what language do you speak? ______________________

OBSTETRICIAN SPECIALIST OR REFERRAL DOCTOR

Name ______________________ MD or DO

Practice Name ______________________

City______________ Phone#( ) ______________

FAMILY DOCTOR OR OBSTETRICIAN

Name ______________________ MD or DO

Practice Name ______________________

City______________ Phone#( ) ______________

INSURANCE COVERAGE

Primary Insurance Name ______________________

Subscriber's Full Name______________ DOB __________

Relationship to patient ______________________

Employer______________ SS# ______________

Secondary Insurance Name ______________________

Subscriber's Full Name______________ DOB __________

Relationship to patient ______________________

Employer______________ SS# ______________

Will your baby be covered by the same insurance

as you? ______Yes ______No

Baby's Insurance Name ______________________

Subscriber's Full Name______________ DOB __________

Relationship to patient ______________________

Employer______________ SS# ______________

FINANCIAL ARRANGEMENTS

ALL CO-PAYS ARE DUE AT TIME OF SERVICE.

For your convenience, we offer the following methods of payment. Please check the option which you prefer:

______Cash

______Personal check

______Credit Card

______ I wish to discuss the office's payment policy.

AUTHORIZATION AND RELEASE, PAYMENT AGREEMENT (Please read the following and sign below)

All professional services rendered to the patient are charged to the above indicated responsible parent. Necessary forms will be completed to help expedite insurance carrier payments, however, the parent is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. With my signature, I authorize Pediatric Surgeons of West Michigan, P.C., to furnish &/or receive information to or from any referral physician, facility or insurance carrier concerning the patient's illness and/or treatment. I hereby assign to the physician all payments for medical services rendered to the patient. I understand that I am responsible for any amount not covered by insurance.

DATE: ______________________ SIGNATURE______________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

______________________________ ______________________________

Parent/Guardian Signature

______________________________ ______________________________

Date

Documentation of Failure to Obtain Signed Acknowledgment

On ____________________, 20 , __________________ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to ______________ (the "Patient"). The Patient refused to provide a signature when requested.