PLEASE PRINT CLEARLY

Today's Date is: ____________________

Names of Children

1. ______________________________ M F ____________
Last First Middle Sex Date of Birth

2. ______________________________ M F ____________
Last First Middle Sex Date of Birth

3. ______________________________ M F ____________
Last First Middle Sex Date of Birth

4. ______________________________ M F ____________
Last First Middle Sex Date of Birth

It is important that we know all persons involved in your child's care. We need to know who will carry the insurance on the children. If there are multiple insurance policies, tell us which one is primary and which one is secondary. Please fill in each parent section listed below. Tell us whom we should contact for reminder calls or other pertinent patient information by checking [✓] primary on one of the phone numbers. Communication Policy: LPA will communicate with the parent(s) or guardian(s) who schedule the appointment for the child, attend an appointment, or call the medical advice hotline. It is the parent/guardian's duty to inform an absent parent or guardian of the treatment, status, or follow up information regarding the child. LPA has no obligation to inform an absent parent or guardian of the treatment, status or follow up information regarding the child. With the proper authorization, LPA shall release treatment, status or follow up information to a parent or guardian who contacts LPA.

☐ Parent
☐ Guardian/Other ____________________
Last Name First Name

Street Address

City State Zip County

Social Security Number Date of Birth

Home Phone [ ] **primary** Work Phone [ ] **primary** Cell Phone [ ] **primary**

Employed by Occupation

Medical Insurance and Subscriber

☐ Parent
☐ Guardian/Other ____________________
Last Name First Name

Street Address

City State Zip County

Social Security Number Date of Birth

Home Phone [ ] **primary** Work Phone [ ] **primary** Cell Phone [ ] **primary**

Employed by Occupation

Medical Insurance and Subscriber

☐ Stepparent
☐ Guardian/Other ____________________

Street Address

City State Zip County

Social Security Number Date of Birth

Home Phone[ ] **primary** Work Phone [ ] **primary** Cell Phone [ ] **primary**

Employed by Occupation

Medical Insurance and Subscriber

☐ Stepparent
☐ Guardian/Other ____________________

Street Address

City State Zip County

Social Security Number Date of Birth

Home Phone [ ] **primary** Work Phone [ ] **primary** Cell Phone [ ] **primary**

Employed by Occupation

Medical Insurance and Subscriber

Children Reside With: ☐ Father ☐ Mother ☐ Both ☐ Other: ____________

OVER

Please list any person(s) **authorized to seek medical treatment, information, or advice** pertaining to your child/children:

Name	Relationship

Do Children have: Medicaid Services ☐ Yes ☐ No
Children's Special Health Care Services ☐ Yes ☐ No

In the event of an emergency (weather or safety related) that our office must temporarily interrupt business to seek shelter, you have the option of leaving, but agree to hold Lansing Pediatrics harmless of any injury that may occur as a result of your departure. ☐ I agree

Email Addresses: ______________________ ______________________

Person we may call if unable to reach you for NON medical and medical information:

Name ______________________ Relationship ______________________ Phone ______________________

Previous Physician: ______________________ Referred by: ______________________

FULL PAYMENT IS EXPECTED AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. A fee will be assessed for any insufficient checks returned from the bank and/or retracted credit card payments. The information I have given is correct to the best of my knowledge, and I understand it is my Responsibility to inform this office of any changes in my child's medical or insurance status. I authorize Lansing Pediatric Associates, P.C. to release all information necessary to secure payment and/or authorization info from my/our insurance company. I also understand LPA orders tests based on medical indication, not insurance benefits and it is my responsibility to determine insurance coverage. I also authorize the exchange of information with specialists involved in my/our child's health care.

______________________ Signature of Parent or Guardian

______________________ Date

PLEASE CIRCLE YOUR PRIMARY CARE PHYSICIAN:

Dr. Amendt **Dr. Chapin** **Dr. Hult** **Dr. Israel** **Dr. Klein** **Dr. Loznak** **Dr. Joshua Takagishi**