Michigan Family Physicians
PEDIATRIC REGISTRATION FORM

Date: _____

Patient's Name: _____ Sex: M F Date of Birth: _____

Sibling's Name: _____ Sex: M F Date of Birth: _____

Sibling's Name: _____ Sex: M F Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Mother's Birth Date: _____ Father's Birth Date: _____

Mother's Address: _____ Father's Address: _____

City, State & Zip: _____ City, State & Zip: _____

Home Phone #: _____ Cell: _____ Home Phone #: _____ Cell: _____

Mother's Employer: _____ Father's Employer: _____

Work Phone #: _____ Work Phone #: _____

Mother's Insurance: _____ Father's Insurance: _____

Which policy is the child listed on? _____ Child Lives With: _____

Emergency contact: _____
(State relationship of contact)

I authorize the release of any information pertinent to my case to any insurance company, which is necessary to process my medical claims for any services rendered. I permit a copy of this authorization to be used in place of the original**. I understand I am responsible for any charges not covered by my insurance company.**

_____
Signature of parent/guardian **Date**

***The parent presenting with the child for care, is responsible for all co-pays and balances unless there is a divorce decree on file stating otherwise**.

_____
Signature of parent/guardian **Date**

Please return with your insurance card(s) and driver's license to the front desk. Thank You.

**If billing address is other than either parent, state here:

_____
Name Relationship

_____
Address Phone