Family and Pediatric Medicine of Grand Rapids
4130 Breton Rd SE, Suite B
Grand Rapids, MI, 49512
Phone 616-281-0093 / Fax 616-281-0580

**Account #: ___________________**

# PATIENT REGISTRATION FORM

## PATIENT

Patient Legal Name: ______________________________________________ Social Security Number: _______-_______-____________
Last First M.I.

Date of Birth: _____/_____/_____ Sex: ____

Address: ______________________________________________________________________________________________
City State Zip Code

Home Phone: (_____) ____________________Cell Phone: (_____) ____________________ E-mail: ___________________________________

## RESPONSIBLE PARTY

Legal Name: ___________________________________________________________ Social Security Number: _______-_______-____________
Last First M.I.

Date of Birth: _____/_____/_____ Sex: ____ Driver's License Number: __________________________

Address: ______________________________________________________________________________________________

Home Phone: (______) ____________________Cell Phone: (______) ____________________ E-mail: __________________________________

Employer: _________________________________________________________________ Work Phone: (____) ___________________

Employer Address: ______________________________________________________________________________________
City State Zip Code

Name of Other Responsible Party (if any): __________________________________________ Relation to Patient: ________________________

Social Security Number: ______-______-___________

## INSURANCE(S)

Insurance Name (Primary): __________________________________________________ Subscriber ID#/Group# __________________________

Subscriber Name: ________________________________________________________ Relation to Patient: _____________________________
Last First

Social Security Number: ______-______-____________ Date of Birth: ____/____/_____ Sex: _____

Address: ______________________________________________________________________________________________

Phone: (______) ____________________

Insurance Name (Secondary): _________________________________________________ Subscriber ID#/Group# ________________________

Subscriber Name: ________________________________________________________ Relation to Patient: _____________________________
Last First

Social Security Number: ______-______-____________ Date of Birth: ____/____/_____ Sex: _____

Address: ______________________________________________________________________________________________

Phone: (______) ____________________

## CONTACT

Emergency Contact: ______________________________________________________________ Phone: (_____) ________________________

Relation to Patient: _____________________________________________________ Alternative Phone: (_____) ________________________

**Please list other family members in the same household are patients at this facility**

| Name (Last, First, M.I.) | Date of Birth | Sex |
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**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION**

I hereby authorize the Physician to release any information acquired in the course of treatment necessary to process insurance claims. It is my responsibility to verify my insurance coverage. I understand that I am financially responsible for any non-covered service. If payment arrangement was not made, my unpaid account balance will be forwarded to the Collection Agency after 70 days. I agree that an additional COLLECTION RECOVERY FEE of 35% of the balance will be added to my account to cover extra collection costs.

**Signature of Parent, Patient, or Responsible Party** **Date**