

1

FAMILY INFORMATION SHEET

TODAY'S DATE

Who does the child live with? Mother & Father Mother Father Other _____
 Legal Custody Mother Father Mother & Father Other _____

2

NAME(S) OF PARENTS/GUARDIAN WHOM CHILD(REN) LIVE WITH:

Mother

Father

Name: _____

Date of Birth: _____

Social Security Number: _____

Mailing Address: _____

City/St/Zip: _____

Phone/Cell: _____

Email Address: _____

Employer/Employer Phone: _____

3

EMERGENCY CONTACT: (someone other than whom patient lives with)

Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

4

ALL CHILDREN WHO LIVE IN HOME (INCLUDING PATIENT):

Name: _____ Date of Birth: _____ Sex: M/F

Name: _____ Date of Birth: _____ Sex: M/F

Name: _____ Date of Birth: _____ Sex: M/F

Name: _____ Date of Birth: _____ Sex: M/F

Name: _____ Date of Birth: _____ Sex: M/F

OFFICE USE ONLY

Allergies and Reactions

OFFICE USE ONLY

Date	Allergy	Reaction

Continuing Problem(s)

Date	Problem	Date Received

READ AND SIGN CONSENT FORM ON BACK AND PROVIDE CURRENT INSURANCE CARD PLEASE

Patient Consent

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND CONSENT FOR TREATMENT

With my consent, Kids Creek Children's Clinic may use and disclose Protected Health Information (PHI) about my child(ren) to carry out treatment, payment and healthcare operations. Please refer to Kids Creek Children's Clinic's Notice of Privacy Practices Policy for a more complete description of such use and disclosures.

The Notice of Privacy Practices has been made available to me and I have the right to a copy if I so desire. Kids Creek Children's Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to KCCC 5024 North Royal Drive Traverse City, MI 49684, Attn. Privacy Officer.

With my consent, Kids Creek Children's Clinic may call my home or other designated location and leave a message on the voice mail in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance questions or comments and may call pertaining to my child's clinical care, including but not limited to laboratory results.

With my consent, Kids Creek Children's Clinic may mail my home or other designated location any items that assist in the practice of carrying out treatment, payment or healthcare operations such as appointment reminder cards, and patient statements.

With my consent, Kids Creek Children's Clinic may e-mail my appointment reminder cards and statements. I have the right to request that Kids Creek Children's Clinic restrict how it uses or disclosed my protected health information to carry out treatment, payment or healthcare operations.

By signing this form, I am consenting to Kids Creek Children's Clinic's use and disclosure of my protected health information to carry out the above named treatment, payment and healthcare operations necessary to render quality medical care to my children.

I hereby assign Kids Creek Children's Clinic all payments for medical services rendered to myself or to my dependents. I understand I am responsible for any amount not paid by my insurance company(ies). I am responsible for all services performed by the medical staff. I am responsible for all services deemed not a covered benefit or denied by my insurance company. Any co-payment or deductible is due at the time of the visit. I authorize the use of a photocopy of this assignment in lieu of the original by my signature below.

I understand that I am responsible for all patient payments at the time of service unless other arrangements have been made in advance. I also understand that if my account has to be sent to a collection agency for recovery of a balance, I will be responsible for collection fees incurred.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Kids Creek Children's Clinic may decline to provide treatment to me.

Printed Name of Legal Guardian/Parent

Signature of Legal Guardian/Parent

Date

I also give the person(s) listed below my full permission to seek medical care from a Kids Creek Children's Clinic medical provider including but not limited to: injections, immunizations, laceration repair, urgent medical care, prescriptions, general medical care, and emergency medical care for my children as the situation warrants and I am not available to seek care for my children. (This allows the named parties to bring your child in). This authorization is good until revoked in writing by the parent signing the reverse side of this form or until Kids Creek Children's Clinic is notified that the parental rights of the person signing this form have been terminated:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____