58115 Main Street
New Haven, MI. 48048

(586) 749-4444
Fax (586) 749-9114

PATIENT INFORMATION

Name of Minor/Child: _____
Sex: ☐ M ☐ F Age: _____ Birthdate: _____ Nickname: _____
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific ☐ Other race ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino
Language: _____
Home Address: _____
Mailing Address: _____
Person financially responsible: _____ Home Phone: _____
Work Phone: _____
Pharmacy (Pharmacy Name, City, and major cross streets): _____
_____
Whom may we thank for referring you? _____

PARENTS/GUARDIANS INFORMATION

Father's/Guardian's Name:	Mother's/Guardian's Name:
Address (if different from patient's):	Address (if different from patient's):
Home phone (if different from patient's):	Home phone (if different from patient's):
Work phone (if different from patient's):	Work phone (if different from patient's):
Employer: _____ Soc. Sec. #: _____ Birthdate: _____	Employer: _____ Soc. Sec. #: _____ Birthdate: _____
Do you have insurance coverage for minor/child? ☐ Yes ☐ No	Do you have insurance coverage for minor/child? ☐ Yes ☐ No
Plan Name: _____ Phone No.: _____ Address: _____	Plan Name: _____ Phone No.: _____ Address: _____
Group #: _____ Policy #: _____	Group #: _____ Policy #: _____

Email Address: _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact:
Name: _____ Relationship: _____ Phone: _____
Name: Relationship: Phone:

TENDER CARE
PEDIATRICS

58115 Main Street
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FINANCIAL AGREEMENT

Patient Name: _____ **DOB:** _____

I have read, understand, and accept the above statements.

Parent/Guardian Signature: _____

Parent/Guardian name (printed): _____

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ACKNOWLEDGEMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth:_____

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

Patient/Guardian Signature: _____

Date: _____

Witnesses: _____

Documentation of Failure to Obtain Signed Acknowledgement

On _____, 20___, _____presented this Acknowledgement of Receipt of Notice of Privacy Practices Form to _____ ("the Patient's Guardian"). The Patient's Guardian refused to provide a signature when requested.

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Immunization Insurance Coverage

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Today's Date: _____

The physicians and staff members have explained the importance of understanding my medical insurance policy.

I've been informed that if my medical insurance does not fully cover immunizations, I will be financially responsible for all charges incurred.

I'm told that for a minimal fee, my local health department offers immunizations to the under/non-insured.

Tender Care Pediatrics is now part of the VFC (vaccines for children program).

I fully understand the terms and limitations of my medical insurance policy regarding immunization coverage, including yearly maximums and deductibles.

Parent/Guardian Signature: _____

Date: _____

PERMISSION FOR OTHER CARETAKERS:

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Patient Name: _____ **Date of Birth:** _____

- I hereby authorize Tender Care Pediatrics, PLLC, to release all information necessary to secure the payment of benefits. I request the payment from my insurance company be made directly to Tender Care Pediatrics, PLLC, (or to the party who accepts assignment).
- I authorize the use of this signature on all my insurance submissions whether manual or electronic.
- I certify that the information that I have reported with regard to my insurance coverage is correct.
- I understand that the information provided here will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

WAIVER OF LIABILITY

- I hold the physicians of Tender Care Pediatrics, PLLC, harmless from any financial liability should any of my child's claims be denied by my current insurance company, or any insurance company I may have in the future. I understand that I will be financially responsible for all charges incurred.

Parent/Guardian Signature: _____

Date: _____

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I, _____, give the below names individuals my permission to bring my child, _____, to Tender Care Pediatrics, PLLC, for evaluation and treatment by the physicians of Tender Care Pediatrics. The physicians who care for my child, may disclose health information regarding the evaluation and treatment of my child to the below named individuals.

Parent/Guardian Signature:

Date: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT BENEFIT