Trestlewood Pediatrics, P.C. 5082 Lovers Lane Portage, Michigan 49002 (P) 269-381-0118 (F) 269-381-4610

Patient Demographics

Name of Children -First and Last Name	DOB	Sex	Preferred Name	Pronounced As	Child's Cell #
1.					
2.					
3.					
4.					
5					

Is there a court order for any of your children regarding legal, financial, or physical custody? Yes ___ No ____

Do child/children live with both parents? **Y/N** If not, who is the legal guardian? _____

Parent Information

Parent/Guardian #1: First and Last Name			Parent/Guardian #2: First and Last Name		
Name of Spouse:			Name of Spouse:		
Relationship to Patient:			Relationship to Patient:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Cell phone:		DOB:	Cell phone:		DOB:
Home phone:			Home phone:		
Email address:			Email address:		
Is this child's primary address:			Is this child's primary address:		

What is the preferred phone number for appointment text reminder? _____

If text reminders are not an option please provide either an email or phone number. _____

Insurance Information

Subscriber's Name	Sub DOB	Rel. to Child	Insurance Co Name	Contract, Policy or ID #	Group #	Co-Pay
1.						$
2.						$

Emergency Contact Other Than Parent:

Name _____ Phone _____ Relationship to Patient _____

Name of Person (s) That You Authorize To Obtain Medical Care for Your Children:
Medical care may include; immunizations, in office procedures and injections when needed in the event a parent cannot bring the child to the appointment.

Name	Relationship to Child	Phone #

If you wish to give your older child permission to bring them self, please read and initial below:

_____ Trestlewood Pediatrics, P.C., has my permission to treat my child for wellness with possible immunizations and illnesses, as they are able to bring themselves to the appointment.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby assign to Trestlewood Pediatrics, P.C., all payments for medical benefits rendered to the patients listed on this form. I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

Date Reviewed	Initial	Date Reviewed	Initial	Date Reviewed	Initial