Ryan Family Practice

300 S Rath, Suite 202 • Ludington, Mi 49431 • Phone 231-425-4447 • Fax 231-425-4401

Date

Pediatric Information

Child's Full Name:(Please Print)			Preferred Name:	Social Security Number:
Age:	Birthdate	Race	□ Male □ Female	Home Phone: ( )
Address			City/State/Zip:	
Child Lives With:	□ Parents □ Mother Only □ Father Only	□ Mother (remarried) □ Father (remarried)	□ Grand Parents □ Legal Guardian	□ Other, please specify:

Mothers Name:		Birthdate:	Social Security Number:
Address:		City/State/Zip:	Home Phone: ( )
Mothers Employer:	Address:	City/State/Zip:	Work Phone: ( )
Father's Name		Birthdate:	Social Securtiy Number:
Father's Employer:	Address:	City/State/Zip:	Work Phone: ( )
Nearest Relative, other than Parents:		Relationship:	Home Phone: ( )
Address:		City/State/Zip:	Work Phone: ( )

INSURANCE INFORMATION (Please provide insurance cards for coping)

Primary Insurance	Name of Person on Insurance Card	Birthdate (person name on card)
Secondary Insurance	Name of Person on Insurance Card	Birthdate (person name on card)

Our Policy Regarding Divorced Parent

Our office requires the parent accompanying this child for treatment will be held responsible for all bills. We cannot bill the other parent. If someone other than yourself is responsible for payment of your child's bill it is your responsibility to ensure that the party receives a copy of the bills and you will ultimately be held responsible to their payment.

Authorization and Assignment

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim for my child. My signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, the physician or supplier agrees to accept the charge determination of the insurance company as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance company.

I understand that I am personally responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made.

Signature_____Date_____