Patient Registration Form

Grand Traverse Children's Clinic, PC

Patient's Full Name: _____ _____ _____
Last First MI

DOB: _____ ☐ Female ☐ Male Social Security No. _____

Home Address: _____

City, State, ZIP: _____ Primary Phone: _____

Race: ☐ American Indian or Alaska Native ☐ White
☐ Asian ☐ Other Pacific Islander
☐ Native Hawai'ian ☐ Other Race
☐ Black or African American ☐ Decline to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Report

Language Spoken:

Parent or Legal Guardian Info (NOT STEP-PARENT)

Mark this box if statements go to this address –> ☐

Name: _____ _____
Last First

DOB: _____ ☐ Female ☐ Male Social Security No. _____

Mailing Address: _____

City, State, ZIP: _____

Phone: _____ _____ _____
(check primary phone): ☐ mobile ☐ home ☐ work

Email: _____ Employer: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian (explain): _____

Parent or Legal Guardian Info (NOT STEP-PARENT)

Mark this box if statements go to this address –> ☐

Name: _____ _____
Last First

DOB: _____ ☐ Female ☐ Male Social Security No. _____

Mailing Address: _____

City, State, ZIP: _____

Phone: _____ _____ _____
(check primary phone): ☐ mobile ☐ home ☐ work

Email: _____ Employer: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian (explain): _____

List Names of all Step-Parents and Siblings Living with Patient

Name: _____ _____ _____
Last First MI

DOB: _____ ☐ Female ☐ Male Relationship to Patient: _____

Name: _____ _____ _____
Last First MI

DOB: _____ ☐ Female ☐ Male Relationship to Patient: _____

Name: _____ _____ _____
Last First MI

DOB: _____ ☐ Female ☐ Male Relationship to Patient: _____

Name: _____ _____ _____
Last First MI

DOB: _____ ☐ Female ☐ Male Relationship to Patient: _____

If parents are divorced, who has custody of patient? _____

Parent/Legal Guardian bringing in patient is responsible for payment. Provide custody papers if applicable.
We cannot discuss patient care w/ anyone other than biological parents/LEGAL guardians without an "Authorization to Treat" on file.
Signature allows "Release of Information" to the Insurance (and State, if Lead-tested) and the Assignment of Benefits to be paid to GTCC.
Signature acknowledges GTCC offered you the "Notice of the Privacy Practices" and authorizes GTCC to treat the Patient named above.

TODAY'S DATE:

Signature of Parent, LEGAL Guardian, or Patient (if 18yrs+): _____ ***Relationship to Patient:*** _____

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