FAMILY DOCTORS OF VICKSBURG PC
13320 NORTH BOULEVARD ST. VICKSBURG MI 49097 269-649-2012 FAX: 269-649-3752

MINOR INFORMATION

Today's Date: ________________________ **Fill in all in blanks. Please Print.**

SSN: _________________________(We will need their SSN in order to print records from Bronson or Borgess)

Patient's Name: ____ Male or Female
First MI Last (Circle one)

Date of Birth: ____________ Home Phone: ____________________ Email: ________________________________

Address:

____
Mailing address City State Zip

Mother: ___________________________________ Father: ____

Legal Guardian: ____ (Please provide documentation)

Please list any other adults authorized to seek medical care for the patient (**including stepparents**)

Name(s)/relationship: ____

Do you give permission for the patient to seek medical treatment in the office alone? (Initial) YES __ NO__

Please note: this authorization does not apply to immunizations or referrals.

Emergency Contact & Number: ____

PRIMARY INSURANCE

Insurance Name: _________________________________ Policy/ID Number: ______________________________

Group Number: ____________________Policyholder/Relationship: _____________________________________

Employer: _______________________________ Date of Birth: ____________SSN: __________________________

Address/phone (if different from pt) ____

SECONDARY INSURANCE

Insurance Name: _________________________________ Policy/ID Number: ______________________________

Group Number: ____________________Policyholder/Relationship: _____________________________________

Employer: _______________________________ Date of Birth: ____________SSN: __________________________

Address/phone (if different from pt) ____

PAYMENT POLICY AND CONSENT FOR TREATMENT

"I authorize Family Doctors and its staff to conduct such exams and treatments as may be necessary for proper health care. All information on this registration and medical history forms is correct to the best of my knowledge. Photocopies of such information and authorizations shall be considered as valid as the originals." Payments of all co pays, deductible and non-covered services is due at the time of service unless prior arrangements have been made with the billing manager. Budget payments can be arranged at the time of service. We bill all insurance companies, but do NOT par with all insurance companies. Participation means we collect only the allowed amount by the insurance company's fee schedule. Please check with the receptionist to make sure we participate with your insurance. If any information is missing/incomplete and results in rejection by your insurance company, the bill for any services will be your responsibility. If you have any laboratory/pathology services performed in our office, an outside lab that will bill your insurance may do the testing. Medical information may be sent to your insurance company upon request for payment determination. I have read the above policies and hereby agree to abide by them. In the event of default, I understand and agree that I am legally liable for all costs of collections, including collection fees, reasonable attorney fees, court costs, and other costs to collect this debt. I request payment be made on behalf to Family Doctors of Vicksburg."

Signature: **Relationship:**