Patient Information

Jackson Pediatric Associates
2100 4th Street Jackson MI
517.787.4330

Ethnic Group

Patient: _____ **Date of Birth:** _____ Caucasian Black Asian Hispanic Other

Patient 14+ Cell/Contact Number- _____ **Gender-** _____

Patient: _____ **Date of Birth:** _____ Caucasian Black Asian Hispanic Other

Patient 14+ Cell/Contact Number- _____ **Gender-** _____

Mother/Guardian _____ Date of Birth _____

Address _____ City _____ Zip Code _____

Social Security Number _____ Cell/Primary Phone _____

Place of Employment _____ Work Phone _____

Permission to contact you at work & leave a message Yes No

Email Address _____ Permisson to email you? Yes No

Father/Guardian _____ Date of Birth _____

Address _____ City _____ Zip Code _____

Social Security Number _____ Cell/Primary Phone _____

Place of Employment _____ Work Phone _____

Permission to contact you at work & leave a message Yes No

Email Address _____ Permisson to email you? Yes No

Language(s) Spoken: English Spanish Japanese Sign Language Other _____

Please Note- If addresses are not the same, where do the children reside: Mom Dad Other _____

Emergency Contact

Name & phone number of person to contact if you cannot be reached, other than parent/persons listed above (neighbor, grandparent)

Name _____ Cell/Primary Phone _____

Relationship to the patient(s) _____

Insurance Information

Primary Insurance _____

Policyholder Name _____ Date of Birth _____

Contract # _____ Group # _____

Secondary Insurance _____

Policyholder Name _____ Date of Birth _____

Contract # _____ Group # _____

Authorization, Assignment of Benefits, and Medical Release

I authorize the release & disclosure of any medical information necessary to process my insurance claim(s) to the Jackson Pediatric Associates providers and I authorize payment of medical benefits to be made to Jackson Pediatric Associates for services rendered.

I understand that it is the intent of this medical practice to hold all of my individually identifiable health information-Protected Health Information(PHI) with the utmost level of confidentiality. I consent to my physician & his/her designees & other health providers using or disclosing my PHI for treatment, payment, healthcare operations, & as discribed in the Physician's Privacy Notice. I consent & authorize to the physician & his/her designees disclosing my PHI to Community Health Technology Network-Henry Ford Health for treatment, payment, or healthcare operations, including for my continuing care & treatment. A photocopy of this authorization shall be considered as effective & valid as the original.

Signed _____ Date _____

Relationship to the patient _____