Patient Information (Please print clearly)

Patient's Full Name: ____

Date of birth: _______________ Best Contact Number:___________________________________

Home Address: ____

City:_________________________ Zip:__________

Religious Preference?_____________________ Email address:_________________________________

Preferred written/spoken language? (if other than English) ____

Preferred Pharmacy-please list cross streets:____

Insurance: ______________________________ Secondary Insurance (if applicable):__________________

Policy Holder of Insurance (name and date of birth): ____

Pediatrician's Name: ____

Practice/Group Name: ____

City: ____________________________ Phone number: ___________________________

How did you hear about us? ____

	Mother's Information	Father's Information
Name:	________________________________	________________________________
Date of Birth:	________________________________	________________________________
Employer:	________________________________	________________________________
Phone:	________________________________	________________________________

Address (If different than patient): ____

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Please list Emergency Contacts: Name and Phone (**other than parents)**-*optional*

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Please Complete Both Sides

No-Show Policy

To allow patients access to timely medical care, we require that you call us at least 24 hours prior to your scheduled appointment if it needs to be rescheduled or cancelled. Effective January 1, 2016, we will be charging a fee of $20.00 for any appointments that are missed without calling us within 24 hours of the scheduled appointment time.

Please sign here to acknowledge this policy:____

Financial Responsibility

The following insurances REQUIRE pre-authorization BEFORE date of visit.

Blue Care Network	Global referral required from PCP.
Children's Special Health Care Services	Specialist is required to be on patient's provider list in order to be covered. Please call to have physician added to provider list.
HealthPlus HMO, HealthPlus Medicaid, HealthPlus MiChild	Global referral required from PCP.
United Healthcare Compass (Health Ins. Marketplace)	Referrals may be required. Call PCP.

I have been informed that services provided may not be covered by my insurance carrier, because the services are not considered a covered benefit under my insurance or because I failed to obtain pre-authorization through my insurance provider and/or Primary Care Physician (PCP). I agree to accept full responsibility for all services that are **NOT** covered by my insurance carrier and understand all future visits **MUST** be pre-authorized.

Please sign here to acknowledge this policy:____

Ethnicity and Race Data Collections

Beaumont Hospital is required by Michigan law to collect and report data on ethnicity and race for the tracking of certain medical conditions. Included below are the definitions for ethnicity or race provided by the Michigan Department of Community Health. If you have any questions regarding these definitions or the requirements to collect this data, please contact the MDCH at (517) 335-8900. Please choose all of the categories below that best describe your ethnicity or race. This **will not** affect your care at Beaumont in any way.

☐ Arab or Middle Eastern Descent

☐ Hispanic/Latino

☐ Caucasian

☐ African American

☐ American Indian/Alaskan Native

☐ Native Hawaiian/Pacific Islander

☐ Other/Unknown

☐ Decline to answer