Kentwood Family Physicians, PC
5070 Cascade Road SE, Suite 250
Grand Rapids, MI 49546
Phone: (616)281-9066, Fax: (616)281-0539

Bruce M. Baker, D.O.
Susan L. Baker, D.O.
David L. Byington, D.O.

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____
Last *First* *M.I.*

Sex: ❑ Male ❑ Female Social Security #: _____

Parent / Guardian:_____ Soc. Sec. #:_____

Home Address: _____

City / State / Zip: _____

Phone #: ❑ Home _____ ❑ Work _____ ❑ Mobile _____
(Please check your preferred primary phone number to be reached at)

E-mail Address: _____

Employer: _____

Employer Address:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Next of kin, not living with you: _____

Relationship: _____ Phone #: _____

Address: _____

Emergency Contact: _____ Relationship: _____

Phone #: Home _____ Work _____ Mobile _____

Insurance Company: _____

Address: _____

Policy Holder: _____ Relationship: _____

Policy Holder Soc. Sec. #: _____ Date of Birth: _____

Employer: _____

Is the patient covered by either of the following: ❑ Medicare ❑ Medicaid

I declare that the information provided above is correct to the best of my knowledge:

_____
Signature Date

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Patient Name: _____ **Date of Birth**: _____

Financial Policy: We Participate with many insurance companies and will bill directly any of those with whom we participate. Any charge rejected or not covered by your insurance company will be billed to you. If we do not participate with your insurance or you do not provide us with sufficient information regarding your insurance coverage in a timely manner, you will be held responsible for the entire charge. If you do not have insurance coverage, our office requires payment in full be made at the time of service. You agree to pay in full for services that your health insurance does not cover due to non-payment of your health insurance premiums. Any changes in insurance coverage or policy details must be reported to our office or you will be responsible for your charges. We bill your insurance company as a courtesy to you: you are ultimately responsible for all charges generated in this office in the course of providing medical care to you, including time for missed appointments.

Copays must be paid prior to your visit with the doctor. If you are unable or unwilling to pay your copay prior to your visit you will be asked to reschedule your appointment.

Other important information: Our office hours are Monday through Friday, 8:30AM until 5:00PM. Calls of a routine nature, including prescription refills, should be made during office hours only. If you have an urgent medical need after normal business hours, you should call our regular office phone number. A physician is on call 24 hours per day, 7 days per week. However, if you experience a life-threatening emergency, please call 9-1-1 or proceed directly to the nearest emergency room.

Managed care (HMO, POS, etc.) patients must contact our office for authorizations before receiving care outside our office, including specialists' offices and urgent care services, except in the case of a life-threatening emergency. For urgent after-hours needs, the on-call physician will give you instruction and, if necessary, authorization.

Permission to treat & release records: I authorize Kentwood Family Physicians to provide medical treatment to myself of the above-named patient, for whom I am legally authorized to obtain medical treatment. I further authorize Kentwood Family Physicians to furnish medical information, including diagnoses and copies of my medical record, to my insurance company in order to determine liability for payment and to obtain reimbursement on my behalf. I assign benefits payable, to which I am entitled, directly to Kentwood Family Physicians.

I understand that, during the course of my treatment by Kentwood Family Physicians, the services of a specialist, hospital, laboratory, or other medical provider may be required. By signing this authorization, I give permission to Kentwood Family Physicians to release any part of my medical record that would be pertinent to treatment and/or evaluation by such a medical provider. In addition, I give permission to Kentwood Family Physicians to release any demographic or insurance information (including my Social Security Number if required for billing or payment purposes) to such a medical provider.

I have read and understand the above information. In addition, I agree that a copy of this authorization shall be valid as the original. This authorization may be revoked at any time by written request.

_____

Signature of Patient (or Parent/Guardian) Date

_____

Printed Name of Parent/Guardian Relationship to Patient