PATIENT AND DEMOGRAPHIC INFORMATION

PAINT CREEK PEDIATRICS & ADOLESCENT CARE, P.C.

HERMINIA BIEREMA, M.D.
CRAIG MUELLER, M.D.

200 DIVERSION, SUITE 20, ROCHESTER HILLS, MI 48307
PHONE 248-656-3440 FAX 248-656-8504

I, ____________________________, give permission for Paint Creek Pediatrics & Adolescent Care, P.C. to provide all necessary medical care for my child/children.

In my absence, __________________________________ has my permission to bring my child(ren) to Paint Creek Pediatrics & Adolescent Care, P.C. for the necessary exams and treatment.

I do/do not (please circle one) give my permission for the doctor/staff to give any normal test, lab or diagnostic results to a family member if I cannot by readily reached.

I do/do not (please circle one) give my permission to discuss my healthcare with family members. Please specify names.____

Child's Name #1 ____________________________Birth Date _______________ID#_________________
Child's Name #2 ____________________________Birth Date _______________ID# _________________
Child's Name #3 ____________________________Birth Date _______________ID# _________________
Child's Name #4 ____________________________Birth Date _______________ID# _________________
Child's Name #5 ____________________________Birth Date _______________ID# _________________

Father's Name ______________________________Birth Date _______________SS# _________________
Father's Address____City___________________
State____ Zip_________Father's Phone (Home) ____________________Cell ________________________
Father's Employer___________________________Address____
State____ Zip_________Work Phone _________________email___________________________________

Mother's Name _____________________________Birth Date _______________SS#_________________
Mother's Address____City___________________
State____ Zip_________Mother's Phone (Home) ___________________Cell ________________________
Mother's Employer__________________________Address____
State____ Zip_________Work Phone _________________email___________________________________

Name of Policy Holder___________________________
Primary Insurance____________________________Address_______________________________________
City______________________________ State_____ Zip_________
Group # __________________________ Contract # ________________________
Supplemental Insurance ______________________Address____
City______________________________ State_____ Zip_________
Group # __________________________ Contract # ________________________

Parent Signature ____
Date ____