John A. Boyle, DO, FAAP, FACOP
Roberta A. Bobal-Savage, MD, FAAP
Helen S. Economy, MD, FAAP
Matthew J. Hornik, DO, FAAP
Michelle D. Ober, MD, FAAP
2300 Haggerty Road, Ste. 2110
West Bloomfield, MI 48323
Phone: 248-926-1411, Fax: 248-926-5338

Patient Intake Form

Patient

Last Name _____ M.I._____ First Name _____

Date of Birth_____/_____/_____ Gender_____

Primary Address_____

City _____ State_____ Zip _____

Primary Phone _____ Alternate Phone _____

E-Mail _____

Please list any siblings that are our patients _____

How were you referred to our office? _____

Mother

Last Name _____ First Name _____

Mother's Date of Birth_____/_____/_____

Address_____

City _____ State_____ Zip _____

Primary Phone _____ Alternate Phone _____

Employer _____ Work Phone _____

Father

Last Name _____ First Name _____

Father's Date of Birth_____/_____/_____

Address_____

City _____ State_____ Zip _____

Primary Phone _____ Alternate Phone _____

Employer _____ Work Phone _____

Emergency contact

Last Name _____ First Name _____

Primary Phone _____ Alternate Phone _____

Billing Information

Responsible Party

Last Name _____ First Name _____

Billing Address _____

City _____ State_____ Zip _____

Primary Phone _____ Alternate Phone _____

Date of Birth _____ SSN _____

Relationship to Patient _____

Insurance information

Primary Insurance:

Insurance Name _____

Subscriber Name _____ Date of Birth____/____/____

Subscriber ID _____ Group Number _____

Secondary Insurance:

Insurance Name _____

Subscriber Name _____ Date of Birth____/____/____

Subscriber ID _____ Group Number _____

The Information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform Pediatric Care Corner, P.C. of any changes in my minor/ child's medical, insurance and or financial status. Additionally, I will inform Pediatric Care Corner, P.C. of any address changes that may affect billing. I certify that my minor, child is covered by the above named insurance company or companies, and I assign all insurance benefits to Pediatric Care Corner, P.C., if any, insurance. I hereby authorize Pediatric Care Corner, P.C. and the doctors associated with the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

_____

Printed Name of Patient/ Guardian

_____ _____

Patient/ Guardian Signature Date