

Patient Information for SG Pediatrics of Lake Orion

(BLACK INK ONLY)

Patient's Legal Name: _____ Date of Birth: _____

Preferred Name (if applicable): _____ Gender Assigned at Birth: _____

Patient's Phone Number (16YRS+ ONLY): _____ Cell Phone Home Phone

Do you identify as a different gender than the one assigned to you at birth?

Yes — Please specify: _____ No

Do you have any known drug allergies?

Yes — Please specify: _____ No

Spoken Language (**Please Circle**): English, Indian, Spanish, Russian, Other — Please specify: _____

Mother's (Legal Guardian) Name: _____ Date of Birth: _____

Mother's Address: _____ City: _____ State: _____ Zip: _____

Mother's Cell Phone: _____ Work: _____

Father's (Legal Guardian) Name: _____ Date of Birth: _____

Father's Address: _____ City: _____ State: _____ Zip: _____

Father's Cell Phone: _____ Work: _____

Emergency Contact Name (**Someone not from the same household**): _____

Relationship to Patient: _____ Phone: _____

Preferred Email Address: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

Appointment Reminders: The practice may use your child's information to remind you about upcoming appointments. How would you like to be contacted regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your child's healthcare provided at SG Pediatrics? (Please check all that apply) Text Message Phone call Other: _____

If we are unable to reach you, may we leave a voicemail regarding appointments, treatment, and/or other information pertinent to your child's healthcare provided at SG Pediatrics? Yes No, _____

Persons Authorized to Receive Information: SG Pediatrics may disclose your child's health information to the individuals listed below. These individuals are also authorized to bring your child to appointments and make medical decisions for the child during those visits. **(Do not list any legal guardians if less than 18 years old; leave blank if not applicable.)**

- 1. Name _____ Relationship _____
- 2. Name _____ Relationship _____
- 3. Name _____ Relationship _____
- 4. Name _____ Relationship _____

Policy Acknowledgment and Agreement:

Please check each box below to confirm that you have reviewed the corresponding policies and procedures.

- Responsibility of Charges and Office Financial Policy
- Office Policies
- Vaccine Policy
- Consent to Use and Disclose Protected Health Information
- Text Messaging Privacy Policy and Terms & Conditions

Please select one:

- I Opt-In to receive SMS (text) messages from SG Pediatrics of Lake Orion

By opting in, you agree to receive text messages from us related to your account, appointments, and updates. Message frequency may vary. Message and data rates may apply. For help, reply **HELP** to any message or contact us at 248-683-3385. To opt out at any time, reply **STOP**.

- I Opt-Out of receiving SMS (text) messages. I prefer not to receive communication via text.

By signing below and checking each box, you acknowledge that you have read, understood, and agree to all terms and conditions outlined above.

Print Name _____

Signature _____

Date _____