IHA of Ann Arbor, PC
PO Box 131186
Ann Arbor, MI 48113-1186

CHILDREN'S INFORMATION

NAME (LAST, FIRST, MIDDLE) Please include all of your children that are seen in our office	BIRTHDATE	SEX	RACE	LANGUAGE	ETHNICITY – please check the box that applies	DOES CHILD RESIDE WITH GUARDIAN 1 OR 2 OR BOTH?
					☐ Hispanic ☐ Non – Hispanic ☐Declined	☐1 ☐ 2 ☐ BOTH
					☐ Hispanic ☐ Non – Hispanic ☐Declined	☐1 ☐ 2 ☐ BOTH
					☐ Hispanic ☐ Non – Hispanic ☐Declined	☐1 ☐ 2 ☐ BOTH
					☐ Hispanic ☐ Non – Hispanic ☐Declined	☐1 ☐ 2 ☐ BOTH
					☐ Hispanic ☐ Non – Hispanic ☐Declined	☐1 ☐ 2 ☐ BOTH
					☐ Hispanic ☐ Non – Hispanic ☐Declined	☐1 ☐ 2 ☐ BOTH

PARENT OR GUARDIAN INFORMATION

LEGAL GUARDIAN: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER (SPECIFY) ____

(IF OTHER, PLEASE PROVIDE DOCUMENTATION TO SUPPORT) ☐ DOCUMENTATION ON FILE

PARENT/GUARDIAN #1	BIRTHDATE	PARENT/GUARDIAN #2	BIRTHDATE
RELATIONSHIP TO PATIENT	OCCUPATION	RELATIONSHIP TO PATIENT	OCCUPATION
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
HOME PHONE NUMBER	WORK PHONE NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER
CELL PHONE NUMBER		CELL PHONE NUMBER	
FAMILY EMAIL ADDRESS	EMERGENCY CONTACT – NAME, PHONE NUMBER & RELATIONSHIP		

PRIMARY INSURANCE HOLDER

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT
ADDRESS	CITY, STATE, ZIP		EMPLOYER
NAME OF INSURANCE COMPANY	POLICY #		GROUP #

SECONDARY INSURANCE HOLDER

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT
ADDRESS	CITY, STATE, ZIP		EMPLOYER
NAME OF INSURANCE COMPANY	POLICY #		GROUP #

I CONSENT to the use or disclosure of my protected health information by IHA for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of IHA; AND: In addition IHA may disclose my information to Clinsite a subsidiary of IHA. I understand that I am financially responsible for charges that exceed those covered by my insurance plan and all charges not covered by my insurance plan. By signing below, I ACKNOWLEDGE that I have been offered IHA's Notice of Privacy Practices, including an opportunity to object to certain disclosures of my protected health information.

________________________________ ____ ______________
SIGNATURE OF PATIENT/PARENT/GUARDIAN PRINTED NAME DATE

☐ Form reviewed ________________ Date: ______________ ☐ Form reviewed ________________ Date: ______________

☐ Form reviewed ________________ Date: ______________ ☐ Form reviewed ________________ Date: ______________