Patient Demographic

Patient Last Name: _____**First Name:** _____ **Middle Initial:** _____

Birthdate: ____/_____/_____ **(Please Circle)** Male / Female

Preferred Language: English Spanish Other

Race (circle): White African American Other Decline to Specify

Ethnicity (circle): Hispanic/Latino Non-Hispanic/Latino Decline to Specify

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: (_____) _____ **Cell Number:** (_____) _____

Email Address: _____

Patients Insurance: *We will need to make a copy of your insurance card.*

Insurance #1: _____ **Cardholder's Birthdate:** ____/_____/_____

Insurance #2: _____ **Cardholder's Birthdate:** ____/_____/_____

For pediatric patients, please complete the following:

Father's Name: _____ **(Circle)** Biological Stepparent Adoptive Guardian Foster-Parent

Birthdate: _____/_____/_____ **Phone:** (_____) _____

Address (if different from patient): _____

Employer: _____ **Work Phone:** (_____) _____

Mother's Name: _____ **(Circle)** Biological Stepparent Adoptive Guardian Foster-Parent

Birthdate: _____/_____/_____ **Phone:** (_____) _____

Address (if different from patient): _____

Employer: _____ **Work Phone:** (_____) _____

Patient School: _____ **Phone:** (_____) _____

Patient Daycare: _____ **Phone:** (_____) _____

Other Care Givers: _____ **Phone:** (_____) _____

Siblings in Household: _____
(Full Names and Birthdates)

Emergency Contact: _____ **Phone:** (_____) _____

Preferred Pharmacy: _____ **Phone:** (_____) _____

Mackinaw Trail Pediatrics

Specialists in Children's Healthcare

Patient Pink Sheet

Patient's Name: _____ DOB: / /

Mother's Name: _____ DOB: / /

Father's Name: _____ DOB: / /

Prenatal/Birth History

Pregnancy Doctor: _____ Hospital: _____

Pregnancy Complications: _____

Birth Weight: _____ Labor Complications: _____

# of Days in Hospital: _____ Complication with Baby: _____

Significant Health History:

Major Illnesses: _____Fractures: _____

Operations: _____Hospitalizations: _____

Consulting Specialist/Physicians: _____

Allergies: _____ Medications: _____

Siblings: _____

Where your child has received previous medical care: _____

	Parent	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father	Siblings	Other Family
Asthma							
Birth Defects							
Cancer							
Epilepsy/Seizures							
Diabetes							
Heart Disease							
Kidney/Bladder							
Mental Disorder							
Substance Abuse							
Other:							

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7917 Mackinaw Trail, Cadillac, MI 49601
(231) 779-9700 ~ Fax (231) 779-9765
www.mackinawtrailpediatrics.com

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Patient- Centered Medical Home

A Patient- Centered Medical Home (PCMH) is a trusting partnership between a doctor-led health care team and an informed patient. As your PCMH, our goal is to take care of as many of your needs as possible within our office including coordinating care with other providers and specialists when necessary. As our patient, we ask that if you do receive health care at another facility, please have your records sent to Mackinaw Trail Pediatrics.

Patient's Name: _____DOB: _____

Parent/Guardian Signature: _____

Mackinaw Trail Pediatrics as my Patient-Centered Medical Home has given me the opportunity to read their PCMH brochure. I have also had the opportunity to ask any questions regarding what this means for practice and patient care.

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Notice of Privacy Practices

Parent Signature Page

Patient's Name: _____DOB: _____

I have reviewed the Mackinaw Trail Pediatrics "Notice of Policy Practices" and I have had full opportunity to read and consider the contents of this notice.

Parent/Guardian Printed: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____

Date: _____ MTP Staff Witness: _____

****

Documented a failed attempt to obtain a signed Notice Delivery (above) and why it was not possible. Each attempt MUST be documented below using a code for the reason.

I could not obtain the above signature from the legal representative for the following reason:

A) Refused
B) There was a medical emergency
C) Other: _____

Date: _____ MTP Staff: _____ Code: _____

Date: _____ MTP Staff: _____ Code: _____

Date: _____ MTP Staff: _____ Code: _____

Date: _____ MTP Staff: _____ Code: _____

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