Welcome to West Michigan Family Health, PC

Date: _____

Primary Doctor: □ Dr. Michelle Davis □ Dr. Cindy Opolka □ Dr. Pamela Zelasko

1. Patient Name:_____ DOB: _____ SS#: _____

   Address: _____

   City: _____ County: _____ State: _____ Zip: _____

   Home Phone #:_____Cell #:_____ Work #: _____

   __Male __Female __Minor (under 18) __Single __Married __Divorced __Widowed __Separated __Partner

   Preferred Language: _____ E-mail Address: _____

   Race: ___ American Indian or Alaska Native ___ Asian ___Black or African American
   ___ Native Hawaiian or Other Pacific Islander ___ White ___ Other _____

   Ethnicity: ____ Hispanic or Latino ___ Not Hispanic or Latino

2. Person and Address where bills should be sent. If same as above check here. ☐ Same as above

   Name: _____ Relationship to patient _____

   Address: _____

   City: _____ State:_____ Zip:_____

   Home Phone #:_____Cell #:_____Work #:_____

   DOB: _____ Social Security #:_____

3. Insurance Information

Primary Insurance	Secondary Insurance (if any)
Policy Holder _____	Policy Holder _____
Date of Birth _____ SS# _____	Date of Birth _____ SS#_____
Insurance Co _____	Insurance Co _____
Contract # _____	Contract # _____
Group # _____	Group # _____

4. **Emergency Contact Information -** In the event of an emergency, who should we contact?

   Name: _____ Phone #_____ Relationship_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby give the practice my consent to check my external prescription history. I authorize West Michigan Family Health, PC physicians to treat my child or me. I agree that West Michigan Family Health, PC can contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. West Michigan Family Health, PC can also contact me by sending text messages or emails. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. West Michigan Family Health, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

X_____ (signature of patient or parent if minor)