Physician ____

PATIENT INFORMATION

Date ____

Please Print

New ____________________ Est __________________

Last Name: ___________________________________ First : ____________________________________ M.I.: _____________

Birthdate: ________________________ Male ☐ Female ☐ Patient SS #: ______________________________________

Home Address: ____

City: ____ State: _______________________ Zip: _____________________________

Patient's Home Phone: ____

Mother's Last Name: __________________________ First: ___________________________________ M.I.: ________________

Birthdate: ___________________________________ Social Security #: ____

Home Address:____

City: ____ State: ___________________ Zip: _________________________

Home Phone: _________________________ Work # ____________________________ Cell # __________________________

Employer Name: ____

Employer Address: ____

City: ____ State: _____________________ Zip: _________________________

Please Check One: ☐ Full Time ☐ Part Time

Father's Last Name:__________________________________ First Name:______________________________ M.I.:___________

Birthdate: ______________________________________ Social Security #: ____

Home Address: ____

City: ____ State: ________________________ Zip: _________________________

Home Phone #: ____________________________ Work #: __________________________ Cell # __________________________

Employer Name: ____

Employer Address: ____

City: _______________________________________ State: ____________________________ Zip: ______________________

Please Check One: ☐ Full Time ☐ Part Time

Pediatrician's Last Name: __________________________________ First Name: ___________________________________

Address: ____City: _____________________________ State: ______ Zip: ___________

Phone: ____ Fax: ____

DO NOT **<u>Put Down The Name Of The Practice For Pediatrician Or Referring. We Need The Dr.s Name.</u>**

Referring Physician's Last Name: ____________________________ First Name: ______________________________

Address: ____

City: ____________________________________ State: ________________________ Zip: ___________________________

Phone #: ____ Fax # ____

Pharmacy Name : ____

Address:____

City: ___________________________________ State:______________________________ Zip: _______________________

Phone #: ____ Fax #: ____

Insurance Company Name: ____

Primary Policy Holder Last Name: ____________________________ First Name: __________________________________

Address of Policy Holder:____Birthdate:_________________

City: ____ State: __________________________ Zip: _________________

Insurance Company Name : ____

Secondary Policy Holder Last Name: ______________________________ First Name: ______________________________

Address Of Policy Holder: ____Birthdate:_________________

City: _______________________________________ State: ____________________________ Zip: ____________________

<u>ETHNICITY AND RACE DATA COLLECTIONS</u>

Beaumont Hospital is required by Michigan law to collect and report data on ethnicity and race for the tracking of certain medical conditions. Included below are the definitions for ethnicity or race provided by the Michigan Department of Community Health. If you have and questions regarding these definitions or the requirements to collect this data, please contact the MDCH at (517) 335-8900. Please choose all of the categories below that best describe your ethnicity or race. This will not affect your care at Beaumont in any way. We are collecting it only to meet requirements.

____Arab Descent: Ancestry from the Middle East or North Africa
____Hispanic/Latino: Ancestry from South or Central America or other Spanish culture
____American Indian/Alaskan Native: Having origins form North, Central or South America and who maintain tribal affiliation or community attachment
____Asian: Having origins for the Far East, Southeast Asia or Indian subcontinent
____Caucasian: Having origins form Europe, the Middle East, North Africa or North America
____Native Hawaiian/Pacific Islander: Having origins form Hawaii, Guam Samoa or other Pacific Islands
____ Other/None of the above
____Unknown
____ Decline to answer