



Welcome to Great Lakes Pediatric Associates. Please fill out the following information as accurately as possible. This information will become a permanent part of your medical record here at Great Lakes Pediatric Associates.

Patient's name: \_\_\_\_\_  
Last Name                      First                      Middle                      Suffix

Address: \_\_\_\_\_  
Street

\_\_\_\_\_                      City                      State                      DOB \_\_\_/\_\_\_/\_\_\_\_                      M    F  
Sex (circle)

\_\_\_\_\_                      Zip Code                      Primary/Best Contact #

*Account Information:*  
The following information will be used to bill your insurance company. Please make sure that the information is as accurate and complete as possible. Missing or wrong information may result in billing errors.

**Insurance Guarantor Information: (If address is same write "same")**

\_\_\_\_\_                      Last Name                      Primary/Cell #

\_\_\_\_\_                      First Name                      Middle                      Suffix                      Work Tel #                      Ext.

Address: \_\_\_\_\_                      SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_                      Street

\_\_\_\_\_                      City

\_\_\_\_\_                      Zip Code

**\*\*\*EMAIL FOR PATIENT PORTAL ACCOUNT** \_\_\_\_\_



**Additional Information:**

**The following information will help the doctors and their assistants to contact you when needed:**

\_\_\_\_\_  
Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Name of the person the patient lives with: \_\_\_\_\_

Cell phone # (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name/Someone not living with the child: \_\_\_\_\_  
Please print

Emergency Contact Relationship: \_\_\_\_\_

Emergency Contact Telephone # (\_\_\_\_) \_\_\_\_\_

*All of the information collected on this form is either required by law, or necessary to bill your insurance. Thank you for taking the time to fill out your personal information. Please return these forms, along with your insurance card and driver's license to the receptionist for processing.*