WEST MICHIGAN ORTHOPAEDICS

CHILD REGISTRATION

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

Please complete SECTION 1 if patient is a minor and/or covered by parent's insurance.

Please complete SECTION 2 if you wish to authorize treatment of your minor without a parent/legal guardian present.

SECTION 1

MOTHER'S INFORMATION

Mother's name: _____

Date of birth: _____ Soc Sec #: _____

Street address: _____

City/State/Zip: _____

Home phone: _____ Work/Cell phone: _____

Employer: _____

FATHER'S INFORMATION

Father's name: _____

Date of birth: _____ Soc Sec #: _____

Employer: _____

❑ Please check here if address is same as above.

Street address: _____

City/State/Zip: _____

Home phone: _____ Work/Cell phone: _____

CONSENT FOR TREATMENT

I hereby consent to allow the physicians and/or support staff of West Michigan Orthopaedics to treat my child for his/her orthopaedic condition.

Signature: _____ Date: _____

SECTION 2

CONSENT FOR TREATMENT IN ABSENCE OF PARENT/LEGAL GUARDIAN

I hereby consent to allow the physicians and/or support staff of West Michigan Orthopaedics to provide ongoing medical treatment for my minor child without the presence of a parent or guardian.

Signature: _____ Date: _____