

2020 PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Last Name: _____

Home Address: _____

First Name: _____ Middle Initial: _____

City _____ State _____ Zip Code _____

Nickname (if any): _____

Home Phone Number: _____ - _____ - _____

Sex: Male Female

Cell Phone Number: _____ - _____ - _____

Date of Birth: ____/____/____

BEST NUMBER TO CONTACT YOU: ____ - ____ - ____

Name of Other Siblings in Practice: _____

RELATIVE/GUARDIAN 1 (Person who holds insurance)

LIVES WITH PATIENT: YES NO

Marital Status (circle one): Single Married Divorced Widowed

Relationship to Patient: Mother Father Guardian Self Other: _____

Last Name: _____

Alternate Address (if different than patient): _____

First Name: _____

Date of Birth: ____/____/____

Home Phone: _____ - _____ - _____

Employer: _____

Cell Phone: _____ - _____ - _____

Employer Address: _____

Work Phone: _____ - _____ - _____

EMAIL: _____

RELATIVE/GUARDIAN 2

Marital Status (circle one): Single Married Divorced Widowed

Relationship to Patient: Mother Father Guardian Self Other: _____

LIVES WITH PATIENT: YES NO

Last Name: _____

Alternate Address (if different than patient): _____

First Name: _____

Date of Birth: ____/____/____

Home Phone: _____ - _____ - _____

Employer: _____

Cell Phone: _____ - _____ - _____

Employer Address: _____

Work Phone: _____ - _____ - _____

EMAIL: _____

INSURANCE INFORMATION (Please enter name exactly as it appears on insurance card)

PRIMARY

SECONDARY

Name of Insured: _____

Name of Insured: _____

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Subscriber ID: _____

Subscriber ID: _____

Group ID #: _____

Group ID #: _____

How did you hear of us? Former Patient Neighbor/Friend Web Site Yellow Pages Other: _____

RACE: (Please circle one)

ETHNICITY

LANGUAGE

American Indian or Alaskan Native (I); Asian (A); Black (B)

Hispanic (H)

Caucasian (C); Pacific Islander (P); Other (E)

Non-Hispanic

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS A CLAIM. I ALSO AUTHORIZE PAYMENT DIRECTLY TO DOWNERS GROVE PEDIATRICS, LTD. AND I AGREE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE INCLUDING COLLECTION AND/OR ATTORNEY FEES WHEN APPLICABLE.

Signature of Person Completing Form: _____ Today's Date: _____
