2019 PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Last Name:____

First Name: ____________________________Middle Initial: _____

Nickname (if any):____

Sex: ☐ Male ☐ Female

Date of Birth: ______/______/__________

Name of Other Siblings in Practice:________________________

Home Address: ____

____

City State Zip Code

Home Phone Number:________-________-__________

Cell Phone Number: ________-________-__________

BEST NUMBER TO CONTACT YOU:_______-______-_________

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: ____

First Name: ____

Date of Birth: ______/______/__________

Home Phone: ________-_________-___________

Cell Phone: ________-_________-___________

Work Phone: ________-_________-___________

EMAIL:_____________________________

Alternate Address (if different than patient):

____

____

Employer:____

Employer Address: ____

____

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: ____

First Name: ____

Date of Birth: ______/______/__________

Home Phone: ________-_________-___________

Cell Phone: ________-_________-___________

Work Phone: ________-_________-___________

EMAIL:___________________________________

Alternate Address (if different than patient):

____

____

Employer:____

Employer Address: ____

____

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

PRIMARY

Name of Insured:____

Primary Insurance Carrier: _______________________________

Subscriber ID:____

Group ID #:____

SECONDARY

Name of Insured:____

Secondary Insurance Carrier:________________________________

Subscriber ID:____

Group ID #:____

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

RACE: (Please circle one)

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

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

ETHNICITY

Hispanic (H)

Non-Hispanic

LANGUAGE

____

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:________________________