STREETERVILLE PEDIATRICS 233 EAST ERIE ST #304 CHICAGO, IL 60611 312/280-1480 fax312/280-1485

PATIENT REGISTRATION FORM

CHILD/PATIENT INFORMATION

Last Name: First Name: MI:

Date of Birth: Hospital: Sex:

Referred By?

PARENT #1 (Insured Individual; Mark an "X" in the box for the preferred contact number)

Last Name: First Name: MI: Sex:

Date of Birth: Social Security #: ☐Cell Phone:

Address: ☐Home Phone:

City: State: Zip: ☐Work Phone :

Employer: Occupation:

(*A person other than patient parents*)
Emergency Contact: Emergency Phone:

PARENT #2 (Mark an "X" in the box for the preferred contact number)

Last Name: First Name: MI: Sex:

Date of Birth: Social Security #: ☐Cell Phone:

(*If address is the same as other parent, write "Same*")

Address: ☐Home Phone:

City State: Zip: ☐Work Phone:

Employer: Occupation:

**May we contact you through email? Yes / No e-mail address:*

INSURANCE INFORMATION:

Name of Insurance Company:

Claim Filing Address: Ins Phone:

City/State/Zip: Effective Date:

Policy Identification #: Group #:

Name of Group / Employer: Employer Benefit #:

Employer Address:

NOTICE: All information MUST be complete including the signature below. Incomplete information will result in direct billing for medical services to the guarantor of the account without submission to your insurance company. Payment is due no later than 60 days from the date that service is rendered. *Streeterville Pediatrics, S.C. does not submit claims to any secondary insurance(s).*

Assignment of Medical Benefits – Agreement to Remain Responsible – Please Read Completely

I hereby make assignment of my medical benefits to *Streeterville Pediatrics, S.C.* I agree to pay for insurance co-payments and co-insurance at the time service is rendered. I also agree to make full payment on all claims and any balances relating to claims which remain outstanding and/or unpaid by my insurance company which are older than 60 days from the date that service was rendered (r**egardless of the status of the claim).** I specifically agree to verify acceptance of my medical claim and active coverage with my insurance carrier no later than 30 days from the date of service is rendered and report any problems to the billing department at (847) 776-8887. I understand and agree that there may be additional fees assessed to my account for returned checks, copy of records, and/or inaccurate claim information provided. Delinquent accounts (accounts that contain dates of service older than 90 days) that are transferred to a collection agent may incur additional fees. I authorize this medical provider or the agents thereof to release and/or distribute any and all medical information necessary for settlement of my own or my dependent's claim(s).

Signature: Printed Name: Date:

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PATIENT REGISTRATION FORM

EMERGENCY AND MEDICAL INFORMATION

CHILD'S
LAST NAME: _____ FIRST: _____ DOB: _____

EMERGENCY CONTACT INFORMATION (someone other than parents - e.g.: grandparent/aunt/uncle/friend):

1.Name: _____Relationship:_____

Address: _____Phone:_____

2.Name: _____Relationship:_____

Address: _____Phone:_____

MEDICAL HISTORY

Place of Birth: (Hospital, City, State): _____

Type of Birth: Vaginal / C-Section Mother's OB: _____ Feeding: Breast / Formula

Birth Weight: _____ Length: _____ Discharge Weight: _____ Apgars: _____

Complications of Pregnancy / Birth / Postpartum: _____

_____

Past Medical Problems / Illnesses / Hospitalizations / Surgeries (for older children): _____

_____

Family History of Medical Problems (indicate type and relation to patient): _____

_____

_____

Allergies: _____

FAMILY MEMBERS (list names)

Father _____ Date of Birth: _____

Mother _____ Date of Birth: _____

Child 1 _____ Sex M / F Date of Birth: _____

Child 2 _____ Sex M / F Date of Birth: _____

Child 3 _____ Sex M / F Date of Birth: _____

Child 4 _____ Sex M / F Date of Birth: _____