



Patient Registration

Date: _____
Patient Name: _____ Relationship to Guarantor: _____
Date of Birth: _____ Sex: M ___ F ___ Social Security Number: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Referred By: _____
Next of Kin (not living at address listed above): _____ Relationship: _____
Address: _____

Siblings:	Name	Sex	DOB	SS#

Father's Name: _____ **Date of Birth:** _____
Home Address (if different): _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____ Cell Phone: (____) _____
Employer: _____ Employer Address: _____
Social Security Number: _____ Marital Status: _____

Mother's Name: _____ **Date of Birth:** _____
Home Address (if different): _____
City: _____ State: _____ Zip Code: _____
Home Telephone: (____) _____ Work Telephone: (____) _____ Cell Phone: (____) _____
Employer: _____ Employer Address: _____
Social Security Number: _____ Marital Status: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____ ID Number: _____ Group Number: _____
Full Name of Insured: _____ Policy Type: ___ HMO ___ PPO ___ PPC ___ Other: _____
If you belong to an HMO, do you also have other Group Insurance Coverage? ___ Yes ___ No
Co-Pay Amount: _____
How did you hear about us? _____
Previous Physician: _____

NOTIFY IN CASE OF EMERGENCY!!

Name: _____ Relationship: _____ Phone: (____) _____
Name: _____ Relationship: _____ Phone: (____) _____
Name: _____ Relationship: _____ Phone: (____) _____

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Illini Pediatrics, LLC to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Illini Pediatrics, LLC. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____ Witness: _____