Pediatric Health Care Assoc. Patient Registration Form

PLEASE FILL OUT COMPLETELY

Fax: 847-577-2149

Date / / Parent Or Guardian _____

Last Name Initial First Name

Home Tel ( ) Dad Cell # ( ) *Dad Work # ( )

Mom Cell # ( ) *Mom Work # ( )

Address _____

Number Street City State Zip

Dad's Social Security # Driver's License # **Email**

Mom's Social Security # Driver's License # **Email**

Responsible For the Account ☐ Yes ☐ No If Not Who Is _____ Relationship _____

Parents ☐ Married ☐ Divorced ☐ Single ☐ Other _____

Family Member Information Please List Parents and Only The Children That Come To This Practice

Please Circle I- Insured S- Spouse C- Child O-Other

First Name	Last Name	Sex	Relationship	Birthdate
Father		M / F	I - S - C - O	/ /
Mother		M / F	I - S - C - O	/ /
Child 1		M / F	I - S - C - O	/ /
Child 2		M / F	I - S - C - O	/ /
Child 3		M / F	I - S - C - O	/ /
Child 4		M / F	I - S - C - O	/ /

Please List Additional Children On Reverse Side

Primary Medical Insurance

Name of Policyholder / /

Last First Relationship to Child D.O.B.

Address (*If different than above)

Number Street City State Zip

Insured Employer *Work Phone ( )

Insurance Company Name *** EFFECTIVE DATE OF POLICY** / /

Insurance Address

Number Street City State Zip

ID # **GROUP #** Insurance Phone ( )

Type of Insurance ☐ Regular ☐ PPO ☐ Managed Care ☐ HMO ☐ POS ☐ Other _____

*** DEDUCTIBLES $_____ * COPAY $_____** ☐ Yes ☐ No *** WELL CHILD COVERAGE?** ☐ Yes ☐ No

Does Insurance Cover All Children? ☐ Yes ☐ No If No: Specify Those Not Covered _____

***Pediatric Health Care will file insurance claims for you. However, you are responsible for all fees, regardless of insurance coverage.**

Assignment of Benefits

I Authorize Payments of Medical Benefits To The Above Named Provider For Medical Services Rendered. I Authorize The Release of Any Medical Information Necessary To Process Insurance Claims.

* _____ * _____

Insured Signature Date

Office use only • PG EG NS EC