lindenhurst PEDIATRICS

Patient Registration

(Please Complete This Form in its Entirety)

Patient Name:_____ **Date of Birth:**_____ **Sex: M / F**

Parent/Guardian 1 Information: **Relationship to patient (circle one) Mother Father Other:** _____

Last name:_____ First name:_____ MI:_____ Sex: M / F

Street Address:_____City: _____

State:_____ Zip:_____ Email: _____Date of Birth: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Occupation: _____ Employer:_____

Preferred Contact For Appointment Reminders: ☐ call to cell ☐ call to home

Parent/Guardian 2 Information: **Relationship to patient (circle one) Mother Father Other:** _____

Last name:_____ First name:_____ MI:_____ Sex: M / F

Address:_____City:_____

State:_____ Zip:_____ Email:_____ Date of Birth: _____

Cell phone:_____ Home Phone:_____ Work Phone:_____

Occupation:_____ Employer:_____

Parents are: Married / Single / Divorced (please circle)

Primary Insurance Information:

Insurance Company Name: _____ **Name of Insured**: ☐ Parent 1 ☐ Parent 2 ☐ Other

Street Address: _____ City, State, Zip: _____

DOB of Insured: _____ ID #: _____ Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____ **Name of Insured**: ☐ Parent 1 ☐ Parent 2 ☐ Other

Street Address: _____ City, State, Zip: _____

DOB of Insured: _____ ID #: _____ Group #: _____

Emergency Contact Information:

Contact Name: _____ Cell Phone: _____ Home:_____

Relationship to Patient: _____ Comment: _____

Sibling Information:

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Preferred Pharmacy:_____

How did you hear about Lindenhurst Pediatrics?:_____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, fees for in-office services and/or tests, and any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs).

Also, please be advised our office may contact you via an automated system, or text message, regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for the purposes of patient identification.

Illinois Vaccine Registry (ICARE)

Please be advised that our office submits confidential data of children and adult vaccinations to the ICARE (Illinois Comprehensive Automated Immunization Registry Exchange) per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of patient's immunization history.

External RX History

Our office participates in an electronic prescription service (SureScripts). By signing below you provide authorization for us to access your child's external prescription history from the participating electronic prescription service provider.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____

Guarantor/Parent/ Guardian completing this form (Please Print)

_____

Guarantor/Parent/ Guardian Signature

_____

Date