Patient's First Name	Patient's Last Name	DOB	Sex	
1.				**PLEASE NOTE** ********** *Legal Guardians of patients must provide a copy of court documents
2.				
3.				
4.				

1st Parent/Guardian's Name: _____	**2nd Parent/Guardian's Name: _____**
☐ Male ☐ Female	☐ Male ☐ Female
Relationship: ☐ Parent ☐ Step Parent ☐ Foster Parent	Relationship: ☐ Parent ☐ Step Parent ☐ Foster Parent
☐ *Guardian ☐ Other _____	☐ *Guardian ☐ Other _____
Does Child Live at address below? ___ YES ___ NO	Does Child Live at address below? ___ YES ___ NO
Mail billing statements to address below? ___ YES ___ NO	Mail billing statements to address below? ___ YES ___ NO
DOB: SSN#:	DOB: SSN#:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone: Cell:	Home Phone: Cell:
Work #:	Work #:
Family Email:	How did you hear about Pediatric Health? ☐ Facebook ☐ Internet ☐ Yelp ☐ Twitter ☐ Friends/Family ☐ MD Referral

Primary Insurance:	Secondary Insurance:
Subscriber's Name:	Subscriber's Name:
ID #:_____ Group #:_____	ID #:_____ Group #:_____
Do you have a Co-Pay? $_____	Do you have a Co-Pay? $_____
COPAYS NOT PAID AT TIME OF SERVICE WILL BE CHARGED AN ADDITIONAL $15.00 SERVICE FEE PER PATIENT.	COPAYS NOT PAID AT TIME OF SERVICE WILL BE CHARGED AN ADDITIONAL $15.00 SERVICE FEE PER PATIENT.
Preferred Pharmacy:	Pharmacy Address/Intersection:

Emergency Contact:	Phone:	Relationship to Patient:

******PLEASE NOTE: Failure to provide less than 4 hour notice to cancel or reschedule an appointment will result in fee of $35 for check ups and sports physicals and $25 for all other appointments.***

I have read and agreed to all insurance, consent, appointment, immunization, treatment and payment policies. I consent to have all of my child's (children's) immunizations sent to the State of Illinois I-Care Registry.

_____ _____ _____

Signature: (Parent/Guardian) **Printed Name: (Parent/Guardian)** **Date:**

Front Office Use Only:	Verified:	Scanned:	MU Entered:
Medics:			