

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

1st Parent/Guardian's Name: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> *Guardian <input type="checkbox"/> Other _____ Does Child Live at address below? ___ YES ___ NO Mail billing statements to address below? ___ YES ___ NO DOB: _____ SSN#: _____	2nd Parent/Guardian's Name: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> *Guardian <input type="checkbox"/> Other _____ Does Child Live at address below? ___ YES ___ NO Mail billing statements to address below? ___ YES ___ NO 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? <input type="checkbox"/> Facebook <input type="checkbox"/> Internet <input type="checkbox"/> Yelp <input type="checkbox"/> Twitter <input type="checkbox"/> Friends/Family <input type="checkbox"/> MD Referral

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

Emergency Contact: _____	Phone: _____	Relationship to Patient: _____
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*****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:			