BISKUP & SEGUI PEDIATRIC PARTNERS, P.C.
PATIENT(S) REGISTRATION FORM

Section I- Patient/Parent/Guardian Information

Patient(s) Name:____Preferred Name(s):________________

Primary Address:________________________ City:______________ State:_______ Zip Code:_______

DOB(s):__________Gender at Birth: [M]_____ [F]______ Current Gender Identity (if applicable):_______

Please list parent (guardian) in order of preferred contact:

Parent (Guardian) Name:________________________ DOB: __________ Lives with Patient? Y___ N___

Address:______________________________ City:_____________________ State:_____ Zip:__________

Home Telephone #: __________________ Cell #:____________________ Work #:__________________

Relationship to Child:________________________ E-Mail Address:______________________________

Parent (Guardian) Name:________________________ DOB: __________ Lives with Patient? Y___ N___

Address:______________________________ City:_____________________ State:_____ Zip:__________

Home Telephone #: __________________ Cell #:____________________ Work #:__________________

Relationship to Child:______________________ E-Mail Address:________________________________

The following section relates to additional contacts, i.e., Step Parents, Grandparents, etc. If the following does not apply, please go to Section II.

Additional Guardian Name: _____________________ DOB: __________ Lives with Patient? Y___ N___

Address:_____________________________ City:____________________ State:_____ Zip: ___________

Home Telephone #:_________________ Cell #:_____________________ Work #:___________________

Relationship to Child: ______________________

Additional Guardian Name: _____________________ DOB: __________ Lives with Patient? Y___ N___

Address:_____________________________ City:____________________ State:_____ Zip: ___________

Home Telephone #:_________________ Cell #:_____________________ Work #:___________________

Relationship to Child: ______________________

Section II- Race/Ethnicity

Race: (Check what applies): White____ Asian____African American/Black____Dominican____ Native Hawaiian____

Native American or Alaska Native____ Other Pacific Islander____Other Race____ Decline to Specify____

Ethnicity: Non-Hispanic or Latino____ Hispanic or Latino____ Decline to Specify____

(OVER)

Section III- Insurance Information

Primary Insurance Co:____________________Member ID #______________________ Group #______________

Effective Date:_________SS #:_______________ Subscriber Name:_____________________ DOB:__________

Secondary Insurance Co:____________________Member ID #______________________ Group #____________

Effective Date:_________SS #:_______________ Subscriber Name:_____________________ DOB:_________

Section IV- Pharmacy Information

Preferred Pharmacy #1: ____

Pharmacy Name Address Phone

Preferred Pharmacy #2: ____

Pharmacy Name Address Phone

IMMUNIZATIONS: Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing below, you authorize us to submit this data.

Signature:____ **Date:**_______________________

Parent/Guardian

ELECTRONIC PRESCRIPTIONS: Our electronic medical record program accesses your prescripltion/medication history in order for us to safely prescribe your medication. By signing below, you authorize us to do so.

I authorize the release of any medical information to process a claim. I also authorize insurance payment/benefits to be paid directly to Biskup & Segui Pediatric Partners, P.C. I agree that I am responsible for all non-covered services and for any unpaid balance.

Signature:____ **Date:**______________________

Parent/Guardian

Emergency Contact: Name____________________ Phone #:_____________ Relationship to Patient__________

How were you referred to our practice?____