**Biskup & Segui Pediatric Partners, P.C.**
**Patient(s) Registration Form**

Patient(s) Name: _____
Address: _____
City:_____State:_____ Zip code:_____
Sex: M F Date(s) of Birth: _____

**Preferred contact number where a detailed message can be left:**_____

Ethnicity (Check one): Non-Hispanic Hispanic Refused to Report

Primary race (Check one):

| | | |
|---|---|---|
| White | Asian | Other Pacific Islander |
| Hispanic | Native American | Other Race |
| African American/Black | Native Hawaiian | Unreported/Refused |

**Mother/Guardian Name**:_____
Social Security #:_____ Date of Birth:_____
Marital Status: M S W D
Employer:_____ Occupation:_____
Work Phone:_____
Home Phone:_____ Cell phone:_____
Home Address (if different form patient):_____
City:_____ State:_____ Zip code:_____
Email Address:_____

**Father/Guardian Name:**_____
Social Security #:_____ Date of Birth:_____
Marital Status: M S W D
Employer:_____ Occupation:_____
Work Phone:_____
Home Phone:_____ Cell phone:_____
Home Address (if different form patient):_____
City:_____ State:_____ Zip code:_____
Email Address:_____

**Emergency contact:**

Name:_____Phone #:_____Relationship to patient_____

**Insurance Information:**

**Primary Insurance Company:**_____
Primary Insured's Name:_____ Date of Birth:_____
SS#:_____ Relationship to patient:_____
ID #:_____ Group #:_____ Effective Date:_____

**Secondary Insurance Company:**_____
Primary Insured's Name:_____ Date of Birth:_____
SS#:_____ Relationship to patient:_____
ID #:_____ Group #:_____ Effective Date:_____

**(OVER)**

## Pharmacy Information:

**Preferred Pharmacy #1:**

_____

Name Address Phone Number

**Preferred Pharmacy #2:**

_____

Name Address Phone Number

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

**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 this form, you authorize us to submit this data.

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:_____
(Father, Mother, Guardian, or Self Signature)

How were you referred to our practice:_____