Biskup & Segui Pediatric Partners, P.C.
Adult Patient Registration Form

Patient Name: _____Patient Phone:_____
Address: _____
City:_____State:_____ Zip code:_____
Sex: M F Date of Birth: _____

Patient's Email Address:_____

Ethnicity (Circle what applies):

- Non-Hispanic
- Hispanic
- Refused to Report

Primary race(s) (Circle what applies):

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

Insurance Information:

Primary Insurance Company:_____

Primary Insured's Name (Subscriber):_____

Subscriber's Date of Birth:_____ Relationship to Patient:_____

ID#:_____ Group #:_____ Effective Date:_____

I hereby authorize Biskup & Segui Pediatrics Partners, P.C. to share the specific information described below, to the designated party listed:
Please check only those that apply:

Appt. Dates/Times____ Diagnoses____ Test Results____Medications____ Labs____ Mental Health____

HIV Information____ Alcohol/Drug Information____Other/Specify_____

Designated Party's Name:_____ **Telephone:**_____

(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.

Patient Signature:_____**Date:**_____

Emergency contact:

Name:_____Phone #:_____Relationship to patient_____