**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 Email Address:**_____

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

**Primary race (Circle what applies):**

___White ___Asian ___African American/Black ___Dominican ___Native Hawaiian

___Native American/Alaska Native ___Other Pacific Islander ___Other Race ___Decline to Specify

**Ethnicity (Circle what applies):**

___Non-Hispanic ___Hispanic ___Decline to Specify

**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 from patient):_____
City:_____ State:_____ Zip code:_____

**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 from patient):_____
City:_____ State:_____ Zip code:_____

**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

**Emergency contact:**

Name:_____Phone #:_____Relationship to patient_____

**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)

How were you referred to our practice:_____