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

Patient Name: _____Preferred Name:_____
Date of Birth:_____ Patient Phone:_____
Gender at Birth: [M]_____[F]_____ Current Gender Identity (if applicable):_____
Address: _____City:_____State:_____ Zip code:_____

Patient's Email Address:_____

Race (circle what applies):

. White____ . Asian____ . African American/Black____

. Dominican____ . Native Hawaiian____ . Other Pacific Islander____

. Native Amer./Alaska Native____ . Other Race____ . Declined to Specify____

Ethnicity (circle what applies):

. Hispanic____ . Non-Hispanic____ . Declined to Specify____

Insurance Information:

Primary Insurance Company:_____

Insured's Name (Subscriber):_____

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

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

Secondary Insurance Company:_____

Insured's Name (Subscriber):_____

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

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

(OVER)

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:**_____

Pharmacy Information:

Preferred Pharmacy #1:

_____

Name Address Phone Number

Preferred Pharmacy #2:

_____

Name Address Phone Number

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.

Patient Signature_____ **Date:**_____

ELECTRONIC PRESCRIPTIONS: Our electronic medical record program accesses your prescription/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.

Patient Signature_____ **Date:**_____

Emergency contact:

Name:_____Phone #:_____Relationship to patient_____