

patient registration—child

DuPage Medical Group

WE CARE FOR YOU

Please complete both sides of this form

PHYSICIAN NAME

DATE

patient 1 information (please print)					
PATIENT NAME (last, first, middle)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	
ADDRESS		CITY / STATE / ZIP	COUNTY	HOME PHONE # ()	
NICKNAME	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NAME OF SCHOOL	PRIMARY LANGUAGE	RACE	
patient 2 information					
PATIENT NAME (last, first, middle)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	
ADDRESS		CITY / STATE / ZIP	COUNTY	HOME PHONE # ()	
NICKNAME	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NAME OF SCHOOL	PRIMARY LANGUAGE	RACE	
mother's information (or legal guardian)		father's information			
MOTHER'S NAME		DATE OF BIRTH	FATHER'S NAME		DATE OF BIRTH
ADDRESS (if different from patient)		ADDRESS (if different from patient)			
CITY / STATE / ZIP		CITY / STATE / ZIP			
SOCIAL SECURITY #	HOME PHONE # ()	SOCIAL SECURITY #	HOME PHONE # ()		
EMAIL ADDRESS	CELL / PAGER # ()	EMAIL ADDRESS	CELL / PAGER # ()		
OCCUPATION	WORK PHONE # ()	OCCUPATION	WORK PHONE # ()		
EMPLOYER		EMPLOYER			
EMPLOYER ADDRESS		EMPLOYER ADDRESS			
EMPLOYER CITY / STATE / ZIP		EMPLOYER CITY / STATE / ZIP			
emergency contact					
NAME				LEGAL GUARDIAN <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOME PHONE #	WORK PHONE #	RELATIONSHIP TO PATIENT <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> STEP PARENT <input type="checkbox"/> FRIEND <input type="checkbox"/> AUNT / UNCLE <input type="checkbox"/> BROTHER / SISTER <input type="checkbox"/> OTHER			
primary & secondary insurance (attach copy of the front & back of insurance cards)					
PRIMARY INSURANCE COMPANY NAME		SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #	
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> STEP PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	EFFECTIVE DATE	
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP		COPY	
SECONDARY INSURANCE COMPANY NAME		SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #	
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> STEP PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	EFFECTIVE DATE	
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP		COPY	

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

authorization for release of information

I authorize DUPAGE MEDICAL GROUP to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify DUPAGE MEDICAL GROUP in writing of any information I do not want released.

X

SIGNATURE

DATE

patient registration—child

DuPage Medical Group

WE CARE FOR YOU

To simplify future visits, please complete the information in order for us to register all of your children in your family. *Thank you*

patient 3 information				
PATIENT NAME (<i>last, first, middle</i>)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
ADDRESS		CITY / STATE / ZIP	COUNTY	HOME PHONE # ()
NICKNAME	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NAME OF SCHOOL	PRIMARY LANGUAGE	RACE
patient 4 information				
PATIENT NAME (<i>last, first, middle</i>)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
ADDRESS		CITY / STATE / ZIP	COUNTY	HOME PHONE # ()
NICKNAME	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NAME OF SCHOOL	PRIMARY LANGUAGE	RACE
patient 5 information				
PATIENT NAME (<i>last, first, middle</i>)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
ADDRESS		CITY / STATE / ZIP	COUNTY	HOME PHONE # ()
NICKNAME	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NAME OF SCHOOL	PRIMARY LANGUAGE	RACE
patient 6 information				
PATIENT NAME (<i>last, first, middle</i>)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
ADDRESS		CITY / STATE / ZIP	COUNTY	HOME PHONE # ()
NICKNAME	STUDENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NAME OF SCHOOL	PRIMARY LANGUAGE	RACE

assignment of benefits

I authorize the assignment of benefits payable to DUPAGE MEDICAL GROUP and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

authorization for treatment

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

X _____ | _____
SIGNATURE DATE

