HINSDALE PEDIATRIC ASSOC., S.C. FAMILY INFORMATION FORM

Our office will soon have electronic medical records to better serve you! This is required information.

Father's Name _____ Birth date_____
Last First

Mother's Name _____ Birth date_____
Last First

Children's Address_____ City _____Zip Code_____

COUNTY_____ State_____

Home Phone #(____)_____ Father's Cell Phone #(____)_____ Mother's Cell Phone #(_____)_____

PLEASE CIRCLE PRIMARY PHONE Father's Work Phone#(____)_____ Mother's Work Phone#(____)_____

If parents are separated or divorced, please indicate the name, address, and phone number of the spouse who does NOT live with the child(ren)

_____

PRIMARY EMAIL ADDRESS: _____

PHARMACY _____
Name/Street/ZIP CODE / Phone No.

CHILD or CHILDREN LEGAL NAME required & NICK NAMES (in parenthesis if applicable)

Circle One

First Name_____ Last Name _____ Birth date _____ Male/Female

First Name_____ Last Name _____ Birth date_____ Male/Female

First Name_____ Last Name _____ Birth date_____ Male/Female

First Name_____ Last Name _____ Birth date_____ Male/Female

Please indicate policy that covers the CHILD(REN). (Indicate name of insurance)

Father's Insurance Co_____ Mother's Insurance Co_____

Effective Date: _____ Effective Date: _____

_____

IF the insurance policy holder is a step-parent of the child(ren) please provide the following information so that we may file your **claims correctly:**

Step-parent's name: _____

Date of Birth _____ The relationship to the child(ren)_____

INSURANCE CONTRACT STATES THAT ALL CO-PAYS ARE DUE AT THE TIME OF THE SERVICE

It is your responsibility to be familiar with the specific rules of your plan. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines if you let us know at EACH time of service, exactly what those guidelines are. If your insurance company is not one we are contracted with, we will submit your claims; however no discounts will be given. This does not include HMO & POS policies.

ASSIGNMENT AND RELEASE

I, the undersigned, acknowledge the child(ren) have insurance coverage with_____and assign directly to the physicians of Hinsdale Pediatrics all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physicians at Hinsdale Pediatrics to release all information necessary to secure the proper payment of benefits. I authorize the use of this signature on all insurance claims.

Signature_____ Relationship to child(ren)_____ Date _____