A 2 Z PEDIATRICS
550 E. Boughton Rd. Ste. 110
Bolingbrook, IL 60440
(630) 755-5437(KIDS)

# PATIENT REGISTRATION FORM

| | | | | | |
|---|---|---|---|---|---|
| Today's Date: | | | PCP: | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: First: | | | Middle: | | |
| Birth date: | Age: | Sex: ☐M ☐F | Email Address: | Pharmacy Name and Location: | |
| Address: [Address/ P.O Box, City, ST ZIP Code] | | | | | |
| Social Security no.: | | Home phone no.: | | Cell phone no.: | |
| Father Cell Phone no.: | | Mother Cell Phone no.: | | | |
| Other family members seen here: | | | | | |
| **INSURANCE INFORMATION** | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | |
| Person responsible for bill: | Birth date: | Address (if different): | | Home phone no.: | |
| Is this patient covered by insurance? | | ◯ Yes ◯ No | | | |
| Subscriber Employer: | | Employer address: | | Employer phone no.: | |
| Please indicate primary insurance: | | | | \| Secondary: | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: | | | | \| Other: | |
| Name of secondary insurance (if applicable): | | Subscriber's name: | | Group no.: | Policy no.: |
| Patient's relationship to subscriber: | | | | \| Other: | |
| **IN CASE OF EMERGENCY** | | | | | |
| Name of local friend or relative (not living at same address): | | Relationship to patient: | Home phone no.: | Work phone no.: | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize A2Z PEDIATRICS or insurance company to release any information required to process my claims.

Authorization for Release of Information to Email Address (if one is provided above): We collect email addresses for the purpose of notifying patients of business announcements. We do not disclose your personal identifiable information to any outside businesses or organizations, other than for the purpose mentioned in the paragraph above regarding Insurance Claims.

Patient/Guardian signature _____ Date _____