

# Patient Registration - Child

# DuPage Medical Group

WE CARE FOR YOU

PLEASE ADD ADDITIONAL CHILDREN ON BACK OF FORM	PHYSICIAN NAME	DATE
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Patient 1 Information (please print)					
PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	RACE
ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	HOME PHONE	PRIMARY LANGUAGE

Patient 2 Information (please print)					
PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	RACE
ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	HOME PHONE	PRIMARY LANGUAGE

MOTHER'S INFORMATION			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 #	
EM PLOYER	WORK PHONE #		EMPLOYER	WORK PHONE #	

Emergency Contact	
EMERGENCY CONTACT NAME	RELATIONSHIP <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

Primary and Secondary Insurance (attach copy of the front and back of insurance cards)							
PRIMARY INSURANCE COMPANY NAME		SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH		SOCIAL SECURITY #	
GROUP NAME	GROUP #	MEMBER ID/POLICY #	COPAY	EFFECTIVE DATE	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> SELF <input type="checkbox"/> OTHER	EMPLOYER NAME	
SECONDARY INSURANCE COMPANY NAME		SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH		SOCIAL SECURITY #	
GROUP NAME	GROUP #	MEMBER ID/POLICY #	COPAY	EFFECTIVE DATE	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> SELF <input type="checkbox"/> OTHER	EMPLOYER NAME	

<i>I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.</i>	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 the 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.	
SIGNATURE		DATE

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 of 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 cost 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.	
SIGNATURE	DATE



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### Patient 3 Information (please print)

PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	RACE
ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	HOME PHONE	PRIMARY LANGUAGE	

### Patient 4 Information (please print)

PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	RACE
ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	HOME PHONE	PRIMARY LANGUAGE	

### Patient 5 Information (please print)

PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	RACE
ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	HOME PHONE	PRIMARY LANGUAGE	

### Patient 6 Information (please print)

PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER		SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	RACE
ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	HOME PHONE	PRIMARY LANGUAGE	