Central Illinois Pediatric Associates- Welcome to our office !

New Patient Registration

Patient Name - Last: _____ First: _____ MI: ____ **Birth Date:** ___/___/___

Sex: ☐ Male ☐ Female **Street Address**: _____

City: _____ **State**: _____ **Zip**: _____ **Home Phone**: (____) ____-____

School: _____ **Referred By**: _____

Father's Name Last: _____ First: _____ MI: ____ **Birth Date:** ___/___/___ **SS#:** ___-___-___

Occupation/Employer: _____ **Work Phone:** (____) ____-____

Mother's Name Last: _____ First: _____ MI: ____ **Birth date:** ___/___/___ **SS#:** ___-___-___

Occupation/Employer: _____ **Work Phone:** (____) ____-____

Guardian (other than self): _____ **Birth Date:** ___/___/___ **SS#:** ___-___-___

Occupation/Employer: _____ **Work Phone:** (____) ____-____

Emergency Contact (friend or relative): _____ **Address**: _____ **Phone** _____

Insurance & Billing information

Person Responsible is - Father ☐ Mother ☐ or other ☐ Relationship to patient is _____

Billing Address: _____ **Phone#:** (____) ____-____

1) Insurance company: _____ **Effective date:** _____

Subscriber's name: _____ **ID#:** _____ **Group #:** _____

2) Insurance company: _____ **Effective date:** _____

Subscriber's name: _____ **ID #:** _____ **Group #:** _____

Please confirm the following information from your Insurance carrier:

What is your plan deductible? (A deductible is the amount you pay for health care services before your health insurance begins to pay)**:** _____

What is your copay (A copay is a fixed amount you pay for a health care service, when you receive the service)
i) for Well checks: _____ **ii) for Sick visit:** _____

Does your insurance cover well checkups: Yes____/ No_____and immunizations: Yes____/ No_____

Does your insurance requires referral to Specialist: Yes____/ No_____

Which hospital/hospitals in Bloomington-Normal area are covered under your insurance?

_____

Which Labs in Bloomington-Normal area are covered under your insurance?

_____

Payment required at time of service, unless prior arrangements have been made.
COPAY DUE ON DATE OF SERVICE

The information provided is accurate to the best of my knowledge. I will be responsible for any denied payments because of the inaccurate information above.

Parent/Guardian Signature _____ Date _____