Patient Registration - Child

DuPage Medical Group

WE CARE FOR YOU

PLEASE ADD ADDITIONAL CHILDREN ON THE FOLLOWING FORM	PRIMARY PHYSICIAN NAME	DATE

Patient 1 Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SEX	PRIMARY PHONE #	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)	CITY, STATE, ZIP CODE	PRIMARY LANGUAGE

RACE	ETHNICITY

Patient 2 Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SEX	PRIMARY PHONE #	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)	CITY, STATE, ZIP CODE	PRIMARY LANGUAGE

RACE	ETHNICITY

MOTHER, FATHER OR LEGAL GUARDIANS INFORMATION (guarantor is the parent/guardian that the child resides with)

GUARANTOR'S NAME	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)

CITY / STATE / ZIP

PRIMARY PHONE #	EMAIL ADDRESS	SEX	RELATIONSHIP TO PATIENT

Primary and Secondary Insurance with Subscriber Info (attach copy of both sides of insurance cards, claims address required)

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX

RELATIONSHIP TO PATIENT	GROUP #	MEMBER ID/POLICY #	EFFECTIVE DATE	PRIMARY PHONE #	EMPLOYMENT STATUS

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX

RELATIONSHIP TO PATIENT	GROUP #	MEMBER ID/POLICY #	EFFECTIVE DATE	PRIMARY PHONE #	EMPLOYMENT STATUS

Emergency Contact (should be a person not residing at the home address)

EMERGENCY CONTACT NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER

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 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

Patient Registration - Child

DuPage Medical Group

WE CARE FOR YOU

Patient 3 Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SEX	PRIMARY PHONE #	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)	CITY, STATE, ZIP CODE	PRIMARY LANGUAGE

RACE	ETHNICITY

Patient 4 Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SEX	PRIMARY PHONE #	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)	CITY, STATE, ZIP CODE	PRIMARY LANGUAGE

RACE	ETHNICITY

Patient 5 Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SEX	PRIMARY PHONE #	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)	CITY, STATE, ZIP CODE	PRIMARY LANGUAGE

RACE	ETHNICITY

Patient 6 Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SEX	PRIMARY PHONE #	DATE OF BIRTH

ADDRESS (INCLUDE UNIT # IF APPLICABLE)	CITY, STATE, ZIP CODE	PRIMARY LANGUAGE

RACE	ETHNICITY