



Children & Teens location [] Schaumburg [] Barrington [] Algonquin

Patient name _____ Date of Birth _____ Acct # _____
Address: _____ City, State, Zip _____ Phone _____
(office use only)

SEX: Male Female

Siblings: Name _____ M / F DOB _____ Acct# _____
Name _____ M / F DOB _____ Acct# _____
Name _____ M / F DOB _____ Acct# _____
Name _____ M / F DOB _____ Acct# _____

Mothers Name: _____ Fathers Name: _____
Address _____ Address _____
(if different from patients) (if different from patients)
City, State, Zip _____ City, State, Zip _____
Phone (with area code) _____ Phone (with area code) _____
Employer _____ Employer _____
Employer address _____ Employer address _____
Employer phone _____ Employer phone _____

Nearest relative: Name/address/phone _____

INSURANCE INFORMATION:

Primary Insurance:
Insurance Co. Name _____
Ins. Co. Address _____
City, State, Zip _____
Ins. Co. Phone _____
Policy # _____ Group # _____
Policy Holder Name _____
Policy Holder: Date of Birth _____ Sex: M F
Policy Holder Social Security Number _____

Secondary Insurance:
Insurance Co. Name _____
Ins. Co. Address _____
City, State, Zip _____
Ins. Co. Phone _____
Policy # _____ Group # _____
Policy Holder Name _____
Policy Holder: Date of Birth _____ Sex: M F
Policy Holder Social Security Number _____

Employer _____ Employer _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment which could include HIV, communicable disease or drug abuse information.
AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any otherwise payable to me for services.
I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Parent of minor child) _____ Date _____
Revised 08/02 Practice folders/our forms/new patient information sheet