CHILD AND ADOLESCENT HEALTH ASSOCIATES, LTD
1030 N. CLARK STREET, 4th Floor, CHICAGO IL 60610 PHONE: 312.943.6964, FAX: 312.943.6924

PATIENT REGISTRATION FORM

Today's Date:		PCP:	
PATIENT INFORMATION			
Patient's Last name: First: Middle:		Nick Name:	
Birth Date:	Sex: ☐ Male ☐ Female	Siblings & Birth Dates:	
Street Address:	City:	State:	Zip Code:
Mother's Name:	Primary Number: ☐ Cell ☐ Home ☐ Work	Alternate Number: ☐ Cell ☐ Home ☐ Work	Email:
Father's Name:	Primary Number: ☐ Cell ☐ Home ☐ Work	Alternate Number: ☐ Cell ☐ Home ☐ Work	Email:
Emergency Contact Name:	Relationship to Patient:	Emergency Contact Number:	
GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR THE BILL)			
Guarantor Name:	Relationship to Patient:	Birth Date:	
Address, City, State, Zip (If different from above):		Primary Contact Number:	
PRIMARY SUBSCRIBER INFORMATION (PERSON WHO HOLDS THE INSURANCE POLICY)			
Primary Subscriber's Name (If different from above):	Birth Date:	Social Security Number:	Sex: ☐ Male ☐ Female
Address, City, State, Zip (If different from above):		Primary Contact Number:	
Employer: Employer Address:		Employer Phone Number:	
Insurance Company Name:	Type: ☐ PPO ☐ HMO ☐ Other	Policy/ID Number:	
Co-Pay Amount: $	Insurance Company Address:	Group Number:	
SECONDARY SUBSCRIBER INFORMATION (IF APPLICABLE. DETERMINED BY ORDER OF BIRTH MONTH)			
Secondary Subscriber's Name (If different from above):	Birth Date:	Social Security Number:	Sex: ☐ Male ☐ Female
Address (If different from above):		Primary Contact Number:	
Employer: Employer Address:		Employer Phone Number:	
Insurance Company Name:	Type: ☐ PPO ☐ HMO ☐ Other	Policy/ID Number:	
Co-Pay Amount: $	Insurance Company Address:	Group Number:	

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

SIGNATURE: **DATE:**