Pierce Pediatric Associates, S.C.
1525 East 53rd Street, Suite 712, Chicago, IL 60615

FAMILY INFORMATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Social Security number:

Is this your legal name? __ Yes __ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: __ M __ F

Street address:	Apt. no.:	Home phone : ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	__ Dr.	__ Insurance plan	__ Hospital

__ Family	__ Friend	__ Close to home/work	__ Yellow Pages	__ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone : ( )

Occupation:	Employer:	Employer address:	Employer phone : ( )

Is this patient covered by insurance? __ Yes __ No

Please indicate primary insurance	__ [Insurance]			
			__ Medicaid	__ Other

Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	__ Self	__ Spouse	__ Child	__ Other

Name of secondary insurance (if applicable):	Subscriber's name, Social Security number, birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:	__ Self	__ Spouse	__ Child	__ Other

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone : ( )	Work phone : ( )

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

Patient/Guardian signature *Date*