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:			Nickname:	
Birth date:	Sex: o Male o Female	Siblings names and birth dates:		
Street address:		City:	State:	Zip code:
Parent's name:	Primary phone: o cell o home o work	Alternate phone: o cell o home o work	Email:	
Parent's name:	Primary phone: o cell o home o work	Alternate phone: o cell o home o work	Email:	
Emergency contact name:	Relationship to patient:	Emergency contact phone:		
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:	Birth date:	Social security number:	Sex: o male o female	
Address, city, state, zip (if different from above:		Primary contact number:		
Employer: Employer address:		Employer phone:		
Insurance company name:	Type o PPO o HMO o other	Policy/ID number		
Co-pay amount: $	Insurance company address:	Group number:		
SECONDARY SUBSCRIBER INFORMATION				
Primary subscriber's name:	Birth date:	Social security number:	Sex: o male o female	
Address, city, state, zip (if different from above:		Primary contact number:		
Employer: Employer address:		Employer phone:		
Insurance company name:	Type o PPO o HMO o 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:**