Elgin Pediatrics
Karen English, MD, FAAP

# Patient Information

**This form must be completely filled out. Please write legibly.**

**Child's Name (last, first, mi)/date of birth/gender/ ethnicity**

________________________________________/__________/M F/__________

________________________________________/__________/M F/__________

________________________________________/__________/M F/__________

**Address**______________________________________________________

**City-**________________________ **State**________ **Zip**________ **Phone**__________

**Email**________________________________________________________

**How did you hear about us?**__________________________________________

**Parent or Responsible Party**

**Mother**________________________ **Address**__________________________

**Work phone**______________________ **/Cell phone**______________________

**Father**________________________ **Address**__________________________

**Work Phone**______________________ **/Cell phone**______________________

**Emergency Contact**__________________ **/Phone**__________ **/Relationship**__________

**Security Questions: your Mother's Maiden Name**______________________________

**Pet's Name**________________________ **Elementary School**____________________

**Insurance information**

**Insurance Company**______________________________ **Phone #**__________

**Insurance address**____________________________________________

**Policy ID #**______________________________ **Group #**________________

**Policy holder name**__________________________ **Relationship to patient**__________

**Insured's date of birth mm/dd/yyyy**______________ **sex**__________ **SSN**______________

**Address**____________________ **Employer**______________ **phone #**__________

I hereby assign, transfer, and set over to Elgin Pediatrics all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

______________________________________________ ______________________

Signature of responsible party Date