



# Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your healthcare needs.



UNIVERSITY OF ILLINOIS  
COLLEGE OF MEDICINE AT PEORIA

## PATIENT INFORMATION

Child's Name \_\_\_\_\_ M.I. \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Name of Mother/Guardian \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Name of Father/Guardian \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

## PRIMARY PHYSICIAN INFORMATION

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## BILLING INFORMATION

Who is responsible for payment of bill? (Parent) \_\_\_\_\_

## PRIMARY INSURANCE CARRIER INFORMATION

Insurance Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_  
Policy Holder's Social Security Number \_\_\_\_\_  
Group Number \_\_\_\_\_ Policy/I.D. # \_\_\_\_\_

## SECONDARY INSURANCE CARRIER INFORMATION

Insurance Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_  
Policy Holder's Social Security Number \_\_\_\_\_  
Group Number \_\_\_\_\_ Policy/I.D. # \_\_\_\_\_

**PUBLIC AID #** \_\_\_\_\_ **CARD HOLDER'S NAME** \_\_\_\_\_

*(WE WILL MAKE COPIES OF ALL YOUR INSURANCE AND IDPA CARDS)*

I hereby assign all medical and / or surgical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and other health plans to the Peoria Surgical Group, Inc. I understand that I am financially responsible for all charges whether they are paid by an insurance or health plan. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_