



**NORTHWEST SUBURBAN  
PEDIATRICS, S.C.**  
GROW WITH US

Patient Registration Form (Please fill in all fields completely)

**Patient Information**

Child's Full Legal Name: (Last, First, Middle) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex M / F \_\_\_\_\_

Other Children in the family (Last, First) \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex M / F \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex M / F \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex M / F \_\_\_\_\_

Child's Street Address (City, State, Zip Code)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Preferred # to reach you (please label with name)  
 1. (\_\_\_\_\_) \_\_\_\_\_ Name: \_\_\_\_\_ Home / Cell / Work  
 2. (\_\_\_\_\_) \_\_\_\_\_ Name: \_\_\_\_\_ Home / Cell / Work  
 3. (\_\_\_\_\_) \_\_\_\_\_ Name: \_\_\_\_\_ Home / Cell / Work

**This will be how we reach you**  
 May we leave a message on this phone Yes \_\_\_\_\_ No \_\_\_\_\_

Parent's Email Address (please label name): \_\_\_\_\_ Name: \_\_\_\_\_  
 May we contact you via email? Yes \_\_\_\_\_ No \_\_\_\_\_

Race: (Please Circle) American Indian or Alaska Native Asian African American White Native Hawaiian and other Pacific Islander  
 Ethnic Group: (Please Circle) Hispanic Non-Hispanic  
 Language: English \_\_\_\_\_ Other: \_\_\_\_\_

**Emergency Contacts:**

Parent 1: (Last, First, Middle) Sex M / F Home Address (City, State, Zip Code) (if different from above) Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent 2: (Last, First, Middle) Sex M / F Home Address (City, State, Zip Code) (if different from above) Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Who may we thank for referring you to our practice: \_\_\_\_\_

Birth Hospital: \_\_\_\_\_

**Insurance Information:**

Subscriber Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_  
 Secondary Insurance Company: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_  
 Subscriber/Guarantor - Person financially responsible: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Phone #: (\_\_\_\_\_) \_\_\_\_\_

Permission to Treat:

I give permission to Northwest Suburban Pediatrics, S.C. to render treatment to my minor children

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_