# *Information Sheet*

Thank you for choosing our office. In order to properly serve you we need the following information. (Please Print)
If your information has changed, please notify the office promptly.

## PATIENT DATA

| Patient Name (**Last, First, Middle**) | | | | Sex | Birth Date |
|---|---|---|---|---|---|
| Current Mailing Address | City | State | Zip code | (**Area Code**) Home Telephone | |
| CELL Phone | EMAIL Address | | | | |

## FINANCIAL DATA

| Responsible Party's Name (**Last, First, Middle**) | Relationship to Patient | | | Birth Date |
|---|---|---|---|---|
| Current Mailing Address (**If different than above**) | City | State | Zip code | (**Area Code**) Home Telephone |
| Occupation | Social Security Number | | Employer Name | |
| Employer Address | City | State | Zip code | (**Area Code**) Work Telephone |

## Medical Insurance

Do you have medical insurance? ❑Yes ❑ No If Yes, does your insurance company participate with us? ❑ Yes ❑ No (If unsure, ask receptionist) Please *note* : we are not required to file insurance claims for companies that do not participate with us or if we are not considered your primary care physician. You must adhere to the rules of your insurance company. Y*ou must pay your co-pay for each office visit at the time of service*.

| Insurance Company Name | Policy Number | Group Number | Co-pay amount |
|---|---|---|---|
| Insurance Company Address | City | State | Zip code |

## Authorization to Submit Insurance Claims

1. I authorize this office to release any information necessary to process insurance claims.
2. I understand that I am responsible for all charges, regardless of insurance coverage.
3. I hereby assign payment of medical insurance benefits to Naperville Pediatric Associates.
4. I authorize the release of a copy of this authorization to be used in place of the original.
5. **I certify that the above information is correct.**

Signature Date Relation to Patient

## Consent for Treatment

I consent to office care encompassing, by today's standards, routine technical procedures and treatments performed by my child's attending physician or his/her assistant or designee as may be necessary in his/her best medical judgment.

Signature Date Relation to Patient

## Privacy Statement

I hereby acknowledge that I am aware of the Privacy Policies of Naperville Pediatrics posted in the office, on their website at www.napervillepediatrics.com and have been offered a copy of the policy for my review.

Signature Date Relation to Patient