MILESTONES - FOR KIDS' SUCCESS, P.C.

2901 Finley Road Suite 101; Downers Grove, IL 60515
Telephone: 630-792-1800 Fax: 630-792-1801
www.milestones4kids.com

PATIENT REGISTRATION FORM

Patient Name ____ Date of Birth______________________________ Age___________

Address ____ City _______________________State _________ Zip___________

Person completing form____________________________________ Date Completed ____

Relationship to child ______________________________________

How did you hear of Milestones?

Physician___________________________ Friend ___________________________ Internet ___ Insurance ___ Other _________________

Please note: you are required to provide Milestones – For Kids' Success, P.C. a prescription from your child(s) referring physician

FAMILY INFORMATION

Legal Guardian 1 _______________________________________ Legal Guardian 2 _______________________________________

Date of Birth____ Date of Birth____

Address____ Address____

Home Phone____ Home Phone____

Mobile Phone____ Mobile Phone____

Employer____ Employer____

Work Phone____ Work Phone____

SS# (REQ) ____ SS# (REQ) ____

Email____ Email____

Parent/Guardian Status: Married Divorced Separated Widowed Single

Parenting Status: Biological Adopted Foster Other___________________

Individual persons living at home

NAME	RELATIONSHIP TO CHILD	AGE

Other caretakers: ____Phone____________________________

Relationship to child____

PATIENT REGISTRATION FORM

EMERGENCY CONTACTS

In the case of an emergency if you are not available, who may we contact?

Name and Relationship to child____Phone______________________

Name and Relationship to child____Phone______________________

I hereby give permission for Milestones For Kids Success, P.C. to secure any necessary medical care in the event of an emergency during my absence:

Signature of Legal Guardian____ Date______________________

INSURANCE INFORMATION

Individual financially responsible for patient (amounts not covered by insurance) ____

Primary Insurance Plan Name ______________________________________ Insurance Phone number ______________________________

Insured/Card Holder's Name_______________________________________ Relationship to Patient _______________________________

Member ID/ Policy # ____ Group # ____________________________________

Secondary Insurance Plan Name ____________________________________ Insurance Phone number ______________________________

Insured/Card Holder's Name_______________________________________ Relationship to Patient _______________________________

Member ID/ Policy # ____ Group # ____________________________________

PHYSCIAN INFORMATION

Primary Care Physician ____ Phone_______________________________

Address____

Other specialist(s) your child sees - please list below

Name/Specialty____Phone_________________________

Name/Specialty____Phone_________________________

Name/Specialty____Phone_________________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT – (HIPAA) REGULATORY REQUIRED SIGNATURE

My signature confirms that I have received my Notice of Practice from Milestones – For Kids' Success, P.C.

____ ______________________

Signature of Parent/Guardian on above Patient Date