Wheaton Pediatrics, Ltd

55 E. Loop Rd. Suite 301
Wheaton, Il 60189
Phone: 630-690-7300
Fax: 630-690-8019
www.wheatonpediatrics.com

General Information

Child(ren)'s Name (s): Last, First, Middle	Date of Birth:	Age:	Sex: Male	Female
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Parent/Guardian who hold insurance:	Date of Birth:	Marital Status:	Social Security Number:
Home Street Address:	Home Phone:	Cell Phone/Pager:	
City, State, Zip:	Other Phone:	Child lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian (specify):	
Employer Name and Address:		Occupation:	
Name of other parent:	Date of Birth:	Marital Status:	Social Security Number:
Address if different from above:	Home Phone:	Cell Phone/Pager:	
Employer Name and Address:	Work Phone:	Occupation:	
Employer Address:			

Primary Contact Phone Number as stated on HIPAA:
A new HIPAA may be required if phone numbers do not match

Insurance Information

I understand, and agree that, (regardless of my insurance policy), I am responsible for the entire balance on my account, for all professional services provided to the patient. I have read all the information contained in the financial policy and have completed the information below. I certify that to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my dependents health or any of the information below.

Primary Insurance Company Name:	Plan Type: (Circle) HMO / MC / POS / EPO QPOS / PPO / Other	Name of Insured:
ID Number:	Group Number:	Relationship to Patient:

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices for Wheaton Pediatrics, Ltd.

Please initial upon receipt X_____

Acknowledgement of Receipt of Financial Policy

I have received a copy of the terms of the Wheaton Pediatrics Financial Policy. I agree that I am ultimately financially responsible for any professional services rendered regardless of insurance coverage, child support and/or other outside agreements/arrangements. I agree to assign insurance benefits to Wheaton Pediatrics. I also agree that if it becomes necessary to forward my account to a third-party collection agency due to nonpayment for medical services rendered, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency and all related collection expenses. I understand that I am responsible for the charges incurred by my child/children as their legal parent or guardian.
I acknowledge that I have received the Wheaton Pediatrics Financial Policy and have retained a copy for my review.

Please initial upon receipt X_____

X_____
Signature

_____
Please print name above

_____
Date

Account No. _____
Office Use Only