

YOUNG PEDIATRICS

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(PLEASE PRINT)

Registration Form

#3 Sunset Hills Prof. Center
Edwardsville, IL 62025
Phone # 618-655-0015
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www.youngpediatrics.com

Patient Information

Name _____ Soc. Sec # _____
Last Name First Name Initial
Address _____ DOB: _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Sex M F Age _____
 Single Married Widowed Separated Divorced

Parent Information

Mother Name _____ DOB _____ Soc Sec # _____
Mother Employer/Address _____ Occupation _____ Work# _____
Father Name _____ DOB _____ Soc Sec # _____
Father Employer/Address _____ Occupation _____ Work # _____
Marital Status Single Married Widowed Separated Divorced
Siblings Name & Ages _____
School/DayCare _____
Whom my we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____
Person Responsible for Account _____ Relation to Patient _____

Primary Insurance

Subscriber Name _____
Last Name First Name Initial
Relation to Patient _____ Birth Date _____ Soc. Sec# _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
ID # _____ Group# _____ Effective Date _____

Secondary Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____
Last Name First Name Initial
Relation to Patient _____ Birth Date _____ Soc. Sec# _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
ID # _____ Group# _____ Effective Date _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
and assign directly to _____ all insurance benefits if any, otherwise payable to our
practice for services rendered. I understand that I am financially responsible for all charges whether or not paid by
insurance. I hereby authorize _____ to release all information necessary to secure the
payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date