BLOOMINGTON PEDIATRICS & ALLERGY LTD.

Patient Information Sheet

Today's Date: _____

Patient's Birthdate: _____

First Name: _____ **Middle Initial**: ____ **Last Name**: _____

Address: _____ Sex: M____ F____ Transgender ____
House number/Street name City, State, Zip code

Home Phone: _____ **Cell Phone:** _____ **Other:** _____

When an email address is provided, you will be Web enabled to our patient portal:

Email address: _____

Parents names: Last name: _____ First name: _____ Sex: M/F

Last name: _____ First name: _____ Sex: M/F

Do we have permission to contact this person/persons regarding matters of your child's care? ___ Yes ___ No

Ethnicity (check one):

☐ Non-Hispanic
☐ Hispanic
☐ Prefer not to report

Primary race (check all that apply):

☐ White
☐ Asian
☐ African American/Black
☐ Other Pacific Islander
☐ Native American
☐ Native Hawaiian
☐ Other Race
☐ Prefer not to report

Preferred language(check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐ Yes ☐ No

Preferred Pharmacy

Name: _____ Address: _____ City: _____

Electronic Prescriptions: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this form, you authorize us to do so.

Immunizations: Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this form, you authorize us to submit this data.

***continued on reverse**

Insured Subscriber / Responsible Party Information

Name of Primary Insurance Company: _____ ID# _____ Group# _____

Name of Subscriber on the Insurance Card: _____

Subscriber's address, if different from patient: _____

Subscriber's phone number: _____ Subscriber's Employer: _____

Subscriber's Date of Birth: _____ Subscriber's Gender: ☐ Male ☐ Female

Name of Secondary Insurance Company: _____ ID# _____ Group# _____

Name of Subscriber on the Insurance Card: _____

Subscriber's address, if different from patient: _____

Subscriber's phone number: _____ Subscriber's Employer: _____

Subscriber's Date of Birth: _____ Subscriber's Gender: ☐ Male ☐ Female

Responsibility for Payment for Services Rendered

By signing below, I authorize Bloomington Pediatrics & Allergy to submit claims for services rendered to the insurance company/companies listed by me. I authorize the release of protected health information to said insurance companies for the processing of claims. I understand that I am responsible for payment of services rendered and agree to pay any fees for services not covered by insurance, including, but not limited to co-insurance and deductible amounts. I agree to pay at the time of service any co-payment required by my insurance. I also understand I will be held responsible for the payment of any collection fees should my account be sent into collection proceedings.

Signature: _____ **Date**: _____

Guarantor of Payment/Responsible Party

Consent to Medical Treatment

By signing below, I consent to and authorize the physicians, nurses and other healthcare providers at Bloomington Pediatrics & Allergy to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

In addition to the legal guardians of the patient, the persons below are authorized to schedule and/or accompany the patient to their appointments, consent to recommended medical care, and receive health information about the patient. This consent will expire upon the patient's 18th birthday, at which time a new consent must be signed.

Name: **Relationship to patient:**

1. _____

2. _____

3. _____

Signature: _____ **Date**: _____

Parent/Legal Guardian