



# Wheaton Pediatrics, Ltd

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Wheaton, IL 60189  
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www.wheatonpediatrics.com

## General Information:

<b>Child's Name</b> (Last-First-Middle):	Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Siblings: Name, Gender, & Date of Birth			
Parent/Guardian who holds insurance:	Date of Birth:	Marital Status:	Social Security Number:
Home Street Address:	Home Phone:	Cell Phone/pager:	
City, State, Zip:	E-Mail Address:	Child lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Guardian (specify):	
Employer Name:	Occupation:	Work Phone:	
Employer Address:			
Name of Other Parent:	Date of Birth:	Marital Status:	Social Security Number:
Address if different than above:	Home Phone (if different than above):	Cell Phone/pager:	
Employer Name:	Work Phone:	E-Mail Address (if different than above):	
Employer Address:		Occupation:	

## Emergency Contacts:

Nearest relative not living with you:	Relationship:	Phone Number:
In case of emergency, please notify:	Relationship:	Phone Number:
Nearest neighbor/friend not living with you (in the event of an emergency and one of the above cannot be reached)		Phone Number:

## Insurance Information:

Primary Insurance Company Name*:	Plan Type (circle): HMO / MC / POS / EPO QPOS / PPO / OTHER	Address (City, State Zip):	Phone Number:
ID Number:	Group Number:	Name of Insured:	Relationship to patient:

\*You are responsible for submitting to secondary insurance.

Copy of Insurance card obtained?  Yes  No Date obtained: \_\_\_\_\_

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 (or myself). I have read all the information contained in the financial policy and have completed the above answers. 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 my health) or any of the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**(See Reverse of Form to Complete)**

## Welcome!

Welcome to Wheaton Pediatrics. Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment for your services is considered a part of your treatment. Your clear understanding of your financial policy is important to our professional relationship. Please ask our cashier or billing representative if you have any questions about our fees or financial policy.

In addition: A patient registration form must be completed **prior to seeing the doctor or nurse practitioner**  
Payment is required at time of service  
For payment, we accept cash, check, Visa, MasterCard, American Express and DiscoverCard

## Consent to Treat

The signing of this registration form hereby authorizes the clinicians of Wheaton Pediatrics, Ltd. to provide medical services to my child.

## Minor Patients

For unaccompanied minors, please provide them with written authorization (accompanied by a parent/guardian signature) for our medical staff to provide care. We may deny non-emergency care unless a minor presents us with such authorization. The adult accompanying a minor and the parents or guardians are responsible for payment.

## UCR (Usual and Customary Rates)

Wheaton Pediatrics is committed to providing the best treatment possible for our patients and we charge what is usual and customary for the Wheaton area as determined by the majority of insurance carriers. You are responsible for payment regardless of any insurance company's determination of usual and customary rates unless otherwise dictated by a managed care contract.

## Insurance

As a courtesy to our families, we submit all claims to your **primary** insurance company and accept assignment of insurance benefits. Families with managed care must pay their co-pay **at the time services are rendered** as stated in your benefits plan. For your convenience, we can apply co-payments to a major credit card with your authorization on file. If your insurance company has not paid the full balance within 45 days, then the balance of your account will be transferred to your responsibility. Please be advised that some (and perhaps all) of the services we render may be considered "non-covered" by your insurance company. In this case, they are not considered necessary and thus are not covered under your medical insurance plan. You are personally responsible for payment of these non-covered services.

Insurance is a contract between you and your insurance company. We are not a party to this contract unless you have a managed care plan. We request that you provide a credit card number with authorization to bill your account for any applicable co-payments and the balance not paid by your insurance. You are responsible for the timely payment of your account. Please call our office if your insurance changes so we may update our records.

***Please contact your insurance company in advance to see if they cover well child care and vaccines. If they DO NOT, please ask us about the vaccines for children program.***

## Missed Appointments

Please help us serve all of our patients' best by keeping your scheduled appointments. If you need to miss an appointment, please notify us 24 hours in advance. Fees may be attached for missed or no-show appointments. Please ask to see the No show policy for specific information.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date