Pedios, Ltd Patient Registration Form

260 CHICAGO AVE., OAK PARK, IL 60302, 708-383-8070 FAX# 708-383-0811

Parent/Guardian_____ **Home Phone**_____
Address_____ **Cell Phone**_____
City/State/Zip _____ **Work Phone**_____
Sex: Male/Female_____ **Employer**_____

Parent/Guardian_____ **Home Phone**_____
Address_____ **Cell Phone**_____
City/State/Zip _____ **Work Phone**_____
Sex: Male/Female_____ **Employer**_____
Children Reside with:_____

Children's Information

Full Name	Birth Date	Sex	Relationship to Guarantor
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____

Insurance Information:
Primary Insurance_____ **Policy Holder**_____
Policy#_____**Group#**_____**Effective Date**_____
Claims Address _____
_____
Policy Holder's SS#_____**D.O.B.**_____

<u>Authorization of Treatment, Realease of Information, Assignment of Benefits</u>:
I authorize the providers at Pedios, Ltd to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. <u>I have checked with my insurance company and have verified that Pedios, Ltd is listed as a contracted provider for my child.</u> I authorize payment directly to Pedios, Ltd for all medical benefits otherwise payable to me under the terms of my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Signature _____ **Date** _____