Kids First Pediatrics, Ltd.
24600 West 127th Street
Building B, Suite 345
Plainfield, IL 60585
(815) 609-KIDS (5437)
(815) 609-8111 (Fax)

Please Fill Out Completely

PATIENT INFORMATION

Last Name: _______________________________ **Alternate Last Name:** ___________________________

First Name: ______________________________ **Nickname (if any):**______________________________

Middle Initial: ______ **Date of Birth:** _____/ _____/ ______

Sex: Male Female **Social Security No**: _______________________________

Home Address: ____________________________ **Home Phone Number**: ___________________________

____ **Alt. Phone Number**: ____________________________

Names of Siblings in Practice: ____

RELATIVE/GUARDIAN 1 (Person who holds insurance – Please enter name *exactly* as it appears on insurance card)

Relationship to Patient:

Mother Father Guardian Self Other: ________________

Last Name: ______________________________ **Alt. Address (if different than patient)**

First Name: ______________________________ ____

Lives with Patient: Yes No ____

Social Security Number: ____________________ **Date of Birth**: _____/ _____/ ______

Cell Phone Number: ________________________ **E-mail Address**: _________________________________

Work Address: ____________________________ **Work Phone Number**: ___________________________

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RELATIVE/GUARDIAN 2

Relationship to Patient:

Mother Father Guardian Self Other: ________________

Last Name: ______________________________ **Alt. Address (if different than patient)**

First Name: ______________________________ ____

Lives with Patient: Yes No ____

Social Security Number: ___________________ **Date of Birth**: _____/ _____/ ______

Cell Phone Number: ________________________ **E-mail Address**: _________________________________

Work Address: _____________________________ **Work Phone Number**: ___________________________

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INSURANCE INFORMATION

Primary Insurance Carrier: _____________________ **Address to "send claims to:"** *(Often on the back of the card)*

Subscriber ID: ________________________________ ____

Group ID #: __________________________________ ____

Co-Pay Amount: $________________ Check if there is a secondary insurance.

How did you hear of us? Former Patient Neighbor/Friend Web Site
Yellow Pages Other: ___________________________________