

George Skarpathiotis, M.D., S.C.

7110 West 127th Street, Suite 130 | Palos Heights, IL 60463 | (708)923-6300 | Fax (708) 923-6303
8537 South Cicero Ave | Chicago, IL 60652 | (708) 923-6300 | Fax (708) 923-6303
400 E Lincoln Highway | New Lenox, IL 60451 | (708) 923-6300 | Fax (708) 923-6303

Patient Registration Form

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Number: _____ Secondary Number: _____
Mobile (Y/N) Mobile (Y/N)

Race (Check one):

- African American/ Black Asian
- Hispanic Native American White

Ethnicity (Check one):

- Hispanic Non-Hispanic
- Refused to Report

Parent or Guardian Information:

Mother's Name: _____ DOB: _____ SSN: _____

Email Address: _____

Mother's Employer: _____

Employer Address: _____

Work Number: _____

Father's Name: _____ DOB: _____ SSN: _____

Email Address: _____

Father's Employer: _____

Employer Address: _____

Work Number: _____

In case of an emergency, who may we contact?

Name: _____ Phone Number: _____

Insurance Information:

Primary Insurance Company: _____ Insured's Name: _____

Insurance ID: _____ Insurance Group: _____

Secondary Insurance Company: _____ Insured's Name: _____

Insurance ID: _____ Insurance Group: _____

*****All Co-payments are due at the time of visit. Please bring your insurance card at each visit for copy*****

New Patient Medical History Form

Patient's Name: _____ DOB: _____

Primary Insurance: _____ Secondary Insurance: _____

Has your child had any of the following medical problems either at the present time of in the past?

	Yes	No
ADD		
Allergies		
Apnea		
Asthma		
Behavioral Disorders		
Congenital Disorders		
Developmental Disorders		
Emotional Disorders		
Heart Disorders		

Please list below if your child has had any medical conditions that are not listed above:

Family Medical History

Patient's Name: _____

DOB: _____

Please state Yes/No under the medical conditions that each family member may have had or currently has.

	Health Status	YOB	AGE	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Smoker
Father										
Mother										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										
Sibling										
Sibling										
Sibling										
Sibling										

Please list below if you or a family member has had any medical conditions that are not listed above:

George I Skarpathiotis, M.D., S.C.
Pediatrics

PLEASE NOTE:

We are requesting insurance information for our files and/or in the event of hospitalization. We do bill hospital charges directly to all insurance companies. **WE DO NOT BILL FOR NON-CONTRACTED PPO, HMO, AND PRIVATE INSURANCE COMPANIES FOR OFFICE CHARGES. We do bill for covered services under our contracted PPO, HMO, and Private Insurance Companies as well as the contracted Public Aid companies.**

ASSIGNMENT AND RELEASE:

I hereby authorize that my insurance benefits be paid directly to the physician, and that I am financially responsible for non-covered services. I also authorize the physician to release any information required to process this claim.

CO-PAYMENTS AND BALANCES:

According to our contractual agreements with the insurance companies, **ALL COPAYS MUST BE PAID IN FULL BEFORE SEEING THE PHYSICIAN.** In the case of a copay not being paid in full at the time of Check-In, your appointment will be canceled or rescheduled unless there is a life threatening medical condition.

All balances must be paid in full in order to see a doctor for a physical or well-baby appointment. If you cannot pay the balance in full, please contact our billing department as soon as possible.

MEDICAL RECORDS TRANSFER OR REQUEST FOR COPIES:

In care of transfer or request for copies of medical records, an Authorized for Release of Patient Health Information must be completed and signed for copies of any information released from the patient's chart. Our office is contracted with Healthport and they will bill you directly once the records have been copied and sent out. Please be aware that this can take at least two weeks to be completed. In cases of emergency, we will contact the new physician by phone as soon as possible.

For medical/legal reasons, we prefer to send the records directly to the new physician or lawyer except if you request the records to be sent directly to the parent or legal guardian. **WE WOULD APPRECIATE YOUR ACCOUNT BEING PAID IN FULL BEFORE TRANSFERRING ANY MEDICAL RECORDS TO THE NEW PHYSICIAN.**

IN CASE OF A DIVORCE:

- 1.) In case of a divorce, we are requesting a copy of the Court Order regarding patient's custody.
- 2.) In case of a divorce, the parent who brings the patient into the office for medical treatment will be responsible for payment at the time of service.

COMPLAINTS:

Any and all complaints regarding the office of George Skarpathiotis, M.D., S.C. whatsoever, needs to be in writing and directed to Dr. George Skarpathiotis and marked "Personal and Confidential".

Please indicate your acceptance of these terms by signing below.

Signature: _____

Date: _____

Witness: _____



George Skarpathiotis, M.D. S.C
P E D I A T R I C S

Notice of Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices for George Skarpathiotis, MD, SC.

Print Your Name

Date

Signature of Parent/ Legal Guardian

Relationship to Patient

Witness

Date

Name of Patient This Notice Applies To

Date of Birth

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