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:Mobile (Secondary (Y/N)	Number:Mobile (Y/N)
Race (Check one): African American/ Black Hispanic Native Ameri	A <u>si</u> an	Ethnicity (Check one): Hispanic Non-Hispanic Refused to Report
	Parent or Guardian Info	rmation:
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:		
	Number:	
In case	of an emergency, who n	nay we contact?
Name:	Phone	Number:
	Insurance Informat	tion:
Primary Insurance Company:	I	nsured's Name:
Insurance ID:		Insurance Group:
Secondary Insurance Company:_	I	nsured'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

		DOB:		
Primary Insurance:	S	Secondary Insurance:		
Has your child hof in the past?	nad any of the following	medical problems either at t	he present t	
	Yes	No		
ADD				
Allerg	ies			
Apnea				
Asthm	a			
Behavi Disord				
Conge Disord				
Develo Disord	opmental lers			
Emotion Disord				
Heart Disord	lers			

Family Medical History

Patient's Name:		DOB:								
Please state currently ha		ınder tl	ne medi	ical condit	ions that each	family m	ember n	nay have	had or	
	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 be listed above:	clow if yo	ou or a t	family	member h	as had any me	edical con	ditions t	hat are n	oot	
										_

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, <u>ALL COPAYS MUST BE PAID IN</u> <u>FULL BEFORE SEEING THE PHYSICIAN</u>. 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 APPRECIEATE 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 Congidential".

		S	
Please indicate your acceptance	of these terms by signing l	below.	
Signature:		Date:	
Witness:		_	



Notice of Privacy Practices Acknowledgement

Relationship to Patient
Date
Date of Birth
_

Chicago, Illinois 60652

New Lenox, Illinois 60451

7110 West 127th Street

Palos Heights, Illinois 60462