ALL STAR PEDIATRICS, PC
6428 Joliet Road, Suite 201, Countryside, IL 60525
708-352-4448 office - 708-352-1052 Fax

Father's Name: _____ Date of birth: _____
Home Address:_____
Email Address: _____ Best phone number: _____
Employer: _____ Occupation _____

Mother's Name: _____ Date of birth: _____
Home address if different:_____
Email Address: _____ Best phone number: _____
Employer: _____ Occupation _____

Please tell us which number (Text) or email you prefer to be your primary method of contact from our office
_____

Primary pharmacy: _____

☐ I agree that all telephone numbers and email addresses I provide may be used by All Star Pediatrics, and those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages.

CHILDREN'S NAMES:

First Name: _____ Last name: _____ D/O/B_____ OM OF
First Name: _____ Last name: _____ D/O/B_____ OM OF
First Name: _____ Last name: _____ D/O/B_____ OM OF
First Name: _____ Last name: _____ D/O/B_____ OM OF

INSURANCE:

Please indicate which parent is the policy holder and the policy name:

Father's Insurance _____ Mother's Insurance _____
SS#_____ SS#_____

If the insurance policy holder is a step-parent, please provide the following information:

Step parent's name _____ D/O/B _____ Relationship to child _____

Per all Insurance Contracts all Co-payments are due at the time of service.

It is your responsibility to be familiar with the specific rules of your plan. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines if you let us know at EACH time of service, exactly what those guidelines are. If your insurance company is not one we are contracted with, we will submit your claims however no discount will be given.

I, the undersigned, acknowledge the child(ren) have insurance coverage with_____ and assign directly to the physicians of All Star Pediatrics, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physicians at All Star Pediatrics, to release all information necessary to secure the proper payment of benefits. I authorize the use of this signature on all insurance claims.

Signature: _____ Relationship to Child(ren)_____ Date: _____
(Typing your name electronically, will count as your signature.)