Ravenswood Pediatrics – Dr. Todd Ochs
1945 West Wilson Street, Suite 6116
Chicago, IL 60640
872-208-6257

Child Information Sheet

Today's Date: _____

First name: _____ Middle initial: _____ Last name: _____ Sex: ☐M ☐F

Date of Birth: _____ E-mail address: _____

Address: _____
ADDRESS CITY STATE ZIP

Home phone: _____ Cell phone: _____ Work: _____

Preferred method of communication: ☐ Home number ☐ Cell number ☐ Email ☐ Other: _____

Responsible Party: _____
NAME PHONE NUMBER

Address: _____
ADDRESS CITY STATE ZIP

Insurance Company Name: _____ **Policy #** _____ **Group#** _____

Insured: _____
FIRST NAME MIDDLE INITIAL LAST NAME DATE OF BIRTH

Insured: _____
PHONE SSN RELATIONSHIP TO PATIENT

Address: _____
ADDRESS CITY STATE ZIP

Emergency contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your child care? ☐ Yes ☐ No

Ethnicity (check one):
☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

Primary race (check one):
☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐Yes ☐No

Preferred Pharmacy #1: _____ Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

Preferred Pharmacy #2: _____ Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

IMMUNIZATIONS: *Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

I authorize the Attending Physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand I am responsible for all medical fees during my treatment with the Attending Physician.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to the Attending Physician.

Signature: _____ *Date:* _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT