



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

**Please Fill Out Completely**

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**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: \_\_\_\_\_

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**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: \_\_\_\_\_