KEVIN LUE, M.D.

1-2-3 Pediatrics

3925 75th Street, Suite 105

Aurora, IL 60504

Tel: (630) 978-7337 Fax: (630) 978-1341

Patient Registration

Child: (First M Last)	Birthday	Sex	Child: (First M Last)	Birthday	Sex

Mom:		SSN:
Dad:		SSN:
Street Address:		
City/State:	Zip:	Phone: ( )
Emergency Contact:	Relation:	Phone: ( )
Referred by:		
Address:		

Primary Insurance Information

Subscriber's Name: (First M Last)		Birthday:
Home Address:		
City/State/Zip:	Work #: ( )	Ext:
Fax No:	Home No: ( )	Cell #: ( )
SSN:	Sex:	Marital Status:
Employer:	Employer Address:	
City/State:	Zip:	Phone: ( )
Insurance Co:	ID#:	Group#:
Insurance Co Phone:	Address:	

Secondary Insurance Information

Subscriber's Name: (First M Last)		Birthday:
Home Address:		
City/State/Zip:	Work #: ( )	Ext:
Fax No:	Home No: ( )	Cell #: ( )
SSN:	Sex:	Marital Status:
Employer:	Employer Address:	
City/State:	Zip:	Phone: ( )
Insurance Co:	ID#:	Group#:
Insurance Co Phone:	Address:	

Who will be responsible for the bill if not above?		
Address:	City/State/Zip:	Phone:

BENEFITS TO PHYSICIAN: I hereby authorize payments directly to the physician of surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company. **RELEASE OF INFORMATION:** I hereby authorize release of information for insurance claim purposes. I have read and understand all of the above and hereby state that the information is correct to the best of my knowledge.

Name:	Relation to Patient:
Signature:	Date: