SIU Medicine Mobile Health Care Registration Form

Please provide the following information in order for your child to utilize SIU Medicine Mobile Health Care.

Child's Name ____

Birth Date __________________

Name of Parent/Guardian _____________________________________ Relationship to Child __________________

Address ____ City ____________ Zip Code _________

Home Phone ____________________ Cell Phone ______________ Parent's Work Phone ____________

Child's Physician __________________________________ Physician's Phone ____________

Please note: If this is a Foster child you must provide consent from DCFS representative in order to be seen.

If your child has insurance, complete the following:

Person's name on policy and date of birth______________________________ __ /__ / __

Relationship to child ____

Place of Employment ____

Insurance Company Name ____

Group # ___________________________ Policy # ____________________

Secondary Insurance: Insurance Company Name_______________________________

Group #_______________________ Policy #__________________________________

If your child has an Illinois Public Aid Medical Card or All Kids Health Care complete the following:

Child's Recipient number (9 digit #) _____________________

If your child needs medication, what pharmacy do you prefer? ______________________________

Pharmacy address ___________________________________

If your child needs bloodwork sent to a hospital, which hospital do you prefer _____________________________