TODAY'S DATE_____

PATIENT INFORMATION

NAME_____
LAST FIRST MI SUFFIX NICKNAME

MARITAL STATUS (circle one) SINGLE MARRIED WIDOWED DIVORCED OTHER

SOCIAL SECURITY #_____DATE OF BIRTH_____AGE_____

SEX_____PREFERRED LANGUAGE_____

ETHNIC GROUP (circle one) HISPANIC OR LATINO NOT HISPANIC OR LATINO UNKNOWN

RACE (circle one)

AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIN/OTHER PACIFIC ISLANDER WHITE OTHER

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED_____PHONE #_____

CONTACT INFORMATION

PATIENT HOME PHONE#_____PT. WORK PHONE#_____PT. CELL #_____

E MAIL ADDRESS_____

PATIENT ADDRESS_____
STREET CITY STATE ZIP

PATIENT'S EMPLOYER_____ (or circle one) FT STUDENT PT STUDENT RETIRED UNEMPLOYED

NAME OF RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT

RESPONSIBLE PARTY NAME_____ DATE OF BIRTH _____

MAILING ADDRESS OF RESPONSIBLE PARTY_____
STREET CITY STATE ZIP

RESPONSIBLE PARTY HOME PHONE #_____ WORK PHONE#_____ CELL PHONE#_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____

NAME OF INSURED_____

PT. RELATIONSHIP TO INSURED_____

INSURED DOB_____INSURED SS#_____

SECONDARY INSURANCE NAME_____

NAME OF INSURED_____

PT. RELATIONSHIP TO INSURED_____

INSURED DOB_____ INSURED SS#_____

PRIMARY CARE PHYSICIAN_____LOCATION_____PHONE#_____

PHARMACY NAME_____LOCATION_____PHONE#_____

WHO REFERRED YOU TO OUR PRACTICE, IF NOT YOUR PHYSICIAN_____

PATIENT AUTHORIZATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the provider. I understand that I am responsible for notifying the office 24 hours in advance to cancel an appointment, otherwise I will be billed a $25 NO SHOW fee.

Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments, co-insurance and deductibles will be expected to be collected PRIOR to seeing the provider. If your check does not clear the bank, a $25 service fee will automatically be added to your account. Understand any procedure performed in the office may be billed separately in addition to the office visit fee. Any request by the patient for copies of their medical record will incur a handling and copying fee within the Illinois statute. A $50 deposit will be required in advance for all cosmetic procedures, and forfeited if the appointment is not cancelled 24 hours in advance.

My signature below signifies my understanding and willingness to comply with the above policies.

Patient/Parent or Responsible party signature_____ Date:_____