North Suburban Family Medicine

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150 N River Rd., Suite 310
Des Plaines, IL 60016
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PATIENT INFORMATION / REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security #:	Home phone: ( )	Cell phone: ( )	Birth date: / /	Age:	Sex: ❑M ❑ F	
Street address:		City:	State:			
ZIP code:						
Occupation:	Employer:		Work phone: ( )		Extension:	
Social Security #:	Email address:					
Race: ❑ American Indian ❑ Asian ❑ Black/African American ❑ White ❑ Hispanic ❑ More than one	Ethnicity: ❑ African American ❑ American Indian ❑ European Americans ❑ Not Hispanic/Latino ❑ Hispanic/Latino ❑ Unreported		Language: ❑ English ❑ German ❑ Spanish ❑ Italian ❑Polish			
We would appreciate knowing how you learned about our practice. (please check all that apply)	❑ Dr.		❑ Insurance plan	❑ Hospital		
❑ Former patient	❑ Yellow pages		❑ Newspaper ad			
❑ Received card in mail	❑ Internet search	❑ Close to home/work				
❑ Family or ❑ Friend Recommendation	If so, please tell us whom can we thank:					
❑ Other (please explain):						
Other family members seen here:						

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Cell/work phone : ( )

PHARMACY INFORMATION			
Pharmacy name:	Street address:	City/State	Phone: ( )

MEDICAL INSURANCE / GUARANTOR INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Home phone ( )	Cell phone : ( )		
Is this person a patient here? ❑ Yes ❑ No	Address (if different):				
Occupation:	Employer:	Employer address:	Employer phone : ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. #:	Birth date: / /			Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	DOB: / /	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

AUTHORIZATION

I give my consent for North Suburban Family Medicine employees or associates to leave messages on my answering machine or voicemail regarding my medical care, test results, appointment confirmation and payment issue. I also give them permission to discuss these listed issues with the following people:

Name	Home or Cell Phone Number
Signature	Relationship to Patient

AUTHORIZATION

BENEFITS TO NORTH SUBURBAN FAMILY MEDICINE

I hereby authorize payments directly to North Suburban Family Medicine for Surgical and/or Medical benefits. I also understand that I am responsible for any portion of my bill not covered by my Insurance Company, including Medicare.

RELEASE OF MEDICAL INFORMATION

I hereby authorize release of information for Insurance Claim purposes. Photocopies of the insurance cards are as valid as the original. I have read and understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I approve and grant the request of the authorization.

Name of Patient/Guarantor	Date
Signature of Patient/Guarantor	Relationship to Patient
