

patient registration—adult

DuPage Medical Group

WE CARE FOR YOU

Please complete both sides of this form

PHYSICIAN NAME

DATE

patient information (please print)					
PATIENT NAME (last, first, middle)		SOCIAL SECURITY #	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RACE	DATE OF BIRTH
ADDRESS		CITY / STATE / ZIP		COUNTY	MAIDEN NAME
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	HOME PHONE # ()	CELL / PAGER # ()	MAY WE CONTACT YOU BY EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRIMARY LANGUAGE
EMPLOYER (if retired, please indicate here)		OCCUPATION		EMAIL ADDRESS	
EMPLOYER ADDRESS		EMPLOYER CITY / STATE / ZIP		WORK PHONE # ()	EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME
spouse information					
SPOUSE NAME (last, first, middle)			SOCIAL SECURITY #	DATE OF BIRTH	
ADDRESS		CITY / STATE / ZIP		HOME PHONE # ()	
EMPLOYER (if retired, please indicate here)		OCCUPATION		WORK PHONE # ()	
emergency contact 1			emergency contact 2		
NAME (last, first, middle)		RELATIONSHIP <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER <input type="checkbox"/> SPOUSE	NAME (last, first, middle)		RELATIONSHIP <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER <input type="checkbox"/> SPOUSE
HOME PHONE # ()			HOME PHONE # ()		
WORK PHONE # ()			WORK PHONE # ()		
account guarantor					
GUARANTOR OF ACCOUNT (responsible party)			RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	SOCIAL SECURITY #	
ADDRESS		CITY / STATE / ZIP		COUNTY	
EMPLOYER (if retired, please indicate here)			SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	HOME PHONE # ()
EMPLOYER ADDRESS		OCCUPATION		WORK PHONE # ()	
EMPLOYER CITY / STATE / ZIP			EMPLOYMENT DATE	CELL / PAGER PHONE # ()	
primary & secondary insurance (attach copy of the front & back of insurance cards)					
PRIMARY INSURANCE COMPANY NAME		SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME		GROUP #	MEMBER ID / POLICY #	RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	EFFECTIVE DATE
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER CITY / STATE / ZIP		COPY
SECONDARY INSURANCE COMPANY NAME		SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME		GROUP #	MEMBER ID / POLICY #	RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	EFFECTIVE DATE
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER CITY / STATE / ZIP		COPY

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

authorization for release of information

I authorize DUPAGE MEDICAL GROUP to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify DUPAGE MEDICAL GROUP in writing of any information I do not want released.

X

SIGNATURE

DATE

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assignment of benefits

I authorize the assignment of benefits payable to DUPAGE MEDICAL GROUP and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

authorization for treatment

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

X

SIGNATURE

DATE

