Patient Registration - Adult

DuPage Medical Group

WE CARE FOR YOU

PHYSICIAN NAME		DATE

Patient Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	SOCIAL SECURITY NUMBER	SEX ☐ M ☐ F	RACE	DATE OF BIRTH

ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	MAIDEN NAME

MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	HOME PHONE #	CELL/PAGER #	MAY WE CONTACT YOU BY EMAIL? ☐ YES ☐ NO	PRIMARY LANGUAGE

EMPLOYER (IF RETIRED, PLEASE INDICATE HERE)	WORK PHONE #	EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME	EMAIL ADDRESS
	( )		

Emergency Contact 1

EMERGENCY CONTACT NAME	RELATIONSHIP ☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ SON ☐ DAUGHTER ☐ FRIEND ☐ SPOUSE ☐ OTHER
HOME TELEPHONE NUMBER ( )	
WORK TELEPHONE NUMBER ( )	
CELL/MOBILE TELEPHONE NUMBER ( )	

Emergency Contact 2

EMERGENCY CONTACT NAME	RELATIONSHIP ☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ SON ☐ DAUGHTER ☐ FRIEND ☐ SPOUSE ☐ OTHER
HOME TELEPHONE NUMBER ( )	
WORK TELEPHONE NUMBER ( )	
CELL/MOBILE TELEPHONE NUMBER ( )	

Account Guarantor ***If the Patient and the Account Guarantor are the Same- Please proceed to the Insurance Section***

GUARANTOR OF ACCOUNT (RESPONSIBLE PARTY)	RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER	SOCIAL SECURITY NUMBER

ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	DATE OF BIRTH

SEX ☐ M ☐ F	EMPLOYER (IF RETIRED, PLEASE INDICATE HERE)	HOME PHONE #	WORK PHONE #	CELL / PAGER PHONE #
		( )	( )	( )

Primary and Secondary Insurance *(attach copy of the front and back of insurance cards)*

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #

GROUP NAME	GROUP #	MEMBER ID/POLICY #	COPAY	EFFECTIVE DATE	RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ SELF ☐ PARENT ☐ OTHER	EMPLOYER NAME

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #

GROUP NAME	GROUP #	MEMBER ID/POLICY #	COPAY	EFFECTIVE DATE	RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ SELF ☐ PARENT ☐ OTHER	EMPLOYER NAME

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 the 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.

SIGNATURE	DATE

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 of 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 cost 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.

SIGNATURE	DATE