NEW PATIENT REGISTRATION

Referral: _____

Date:_____

Patient's Name:_____ **Gender (circle) Male Female**
LAST FIRST MIDDLE

Address:_____ **Email**:_____@_____

City:_____ **State IL Zip Code: _____ Phone (home):**_____

Cell phone: _____**Work phone**:_____ **Date of birth: _____**

SS#: _____ Family Doctor: _____ **Phone**: _____

Whom to contact in case of emergency? _____ **Relationship? _____**

Phone (home): _____ **Alternate phone:**_____

BC BS IL PPO Insurance Policy ID#_____ **Group #**: _____

Effective date:_____ **Employer** _____

Policy Holder Name:_____ **Date of birth** _____
(Please complete this section if you are ***not*** the policy holder)

Policy Holder SS#: _____

RELEASE OF INFORMATION:

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

Signed:_____ (Patient, or Parent, if patient a minor.)