OAK BROOK allergists DX. DRUG S.

FOR OFFICE USE ONLY (Rev. 10/12)
Ins.
Patient No. _____ Type _____
Provider

NEW PATIENT INFORMATION

PATIENT NAME _____ BIRTH DATE _____ AGE ____
Last First M.I.

☐ SINGLE ☐ DIVORCED
☐ MARRIED ☐ WIDOWED

◯ MALE ◯ FEMALE PRIMARY LANGUAGE_____ NUMBER OF CHILDREN _____

ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____CELL _____ ***MAY WE LEAVE A MESSAGE?*** ◯ ***YES*** ◯ ***NO***

CONTACT PREFERENCE: ◯ ***HOME PHONE*** ◯ ***CELL PHONE***

EMPLOYED BY: _____ BUSINESS PHONE _____

ADDRESS _____ CITY _____ STATE _____ZIP CODE _____

E-MAIL ADDRESS _____
If patient is a minor, please provide guardian's e-mail.

EMERGENCY CONTACT:

NAME _____ ADDRESS _____ PHONE _____

PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT OF SERVICES (PARENT OR GUARDIAN)

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

RELATIONSHIP TO PATIENT _____ HOME PHONE _____

EMPLOYER _____ CELL PHONE _____

ADDRESS _____STATE ____ ZIP _____WORK PHONE _____

REFERRED BY ◯ NEWSPAPER ◯ INTERNET ◯ INSURANCE CARRIER ◯ YELLOW PAGES ◯ FAMILY/FRIEND ◯ PHYSICIAN

REFERRING PHYSICIAN: _____CITY_____PHONE_____

PRIMARY CARE PHYSICIAN: _____ CITY_____PHONE _____

INSURANCE INFORMATION

◯ PPO ◯ HMO
INSURANCE CARRIER_____ ◯ POS OTHER _____

POLICYHOLDER'S ID# _____ GROUP # _____

RELATIONSHIP TO POLICY HOLDER: ◯ SELF ◯ SPOUSE ◯ DOMESTIC PARTNER ◯ CHILD

POLICYHOLDER'S NAME _____BIRTHDATE _____ ◯ MALE ◯ FEMALE

ASSIGNMENT AND RELEASE:
I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services and any and all co-pays. I also authorize the physician to release any information required in the processing of the claim.

SIGNED _____ DATE _____