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### Patient Registration Form

Date: \_\_\_/\_\_\_/\_\_\_

#### Patient Information

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Gender:  Female  Male Preferred Language: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employment Status:  Employed  Unemployed  Self-employed  Student

Race:  White (also Hispanic)  Asian  Other Pacific Islander  Black /African American  American Indian  Mixed race  All Others

Ethnicity: Are you of Hispanic descent?  Yes  No Ethnicity: \_\_\_\_\_ Nationality: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Pharmacy Information: \_\_\_\_\_

#### Insurance Information

Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

#### Responsible or Insured Party (if Different from Above)

Insured Party Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

SS#: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Spouse Name (if applicable): \_\_\_\_\_

1. **Consent for Treatment:** I, the undersigned consent to the medical examination, immunizations, treatment and procedures for the care. I understand that Physicians at Central Medical Clinic of Chicago have been approved by the State of Illinois to provide medical services, dispense drugs and medical supplies. I understand and therefor I consent access to the above named Patient's medical and prescription history.

2. **Release of Information:** To the extent necessary to determine the liability for payment and to obtain reimbursement, I authorize Central Medical Clinic of Chicago to release all or any portions of my medical records to any person, organization, or agency which is or may be liable for all or any portion of the Central Medical Center of Chicago's charges, including but not limited to insurance companies, health service plans, workers' compensation carriers and government agencies. The Department of Health Services of the State of Illinois may audit my medical records for the purpose of Center licensing or for statistical information. Such audits will not compromise the confidentiality of the above named Patient's medical record.

3. **Financial Agreement:** I hereby agree and I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to a physician and/or supplier of services for myself or dependents. I understand I am responsible for any deductibles, co-insurance and/or amounts for services not covered by the insurance carrier. I understand and I agree to pay all bills as presented regardless of insurance coverage. I agree that if it becomes necessary the account will be referred to a collection agency and I shall pay the collection expenses in full.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Signature of Patient's Guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Relationship to Patient: \_\_\_\_\_