Patient Registration - Adult

DuPage Medical Group

WE CARE FOR YOU

PRIMARY PHYSICIAN NAME	DATE

Patient Information *(please print)*

PATIENT NAME (LAST, FIRST MIDDLE)	DATE OF BIRTH	SEX

ADDRESS & UNIT NUMBER IF APPLICABLE	CITY, STATE, ZIP CODE

PRIMARY PHONE NUMBER	EMAIL ADDRESS	PRIMARY LANGUAGE

RACE	ETHNICITY

Account Guarantor ***To comply with HIPAA Guidelines, patients over the age of 18 will be their own responsible party.***

GUARANTOR OF ACCOUNT (RESPONSIBLE PARTY)

Primary and Secondary Insurance with Subscriber Info *(attach copy of both sides of insurance cards, claims address required)*

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	DATE OF BIRTH

ADDRESS & UNIT NUMBER IF APPLICABLE	CITY, STATE, ZIP CODE	SEX

GROUP #	MEMBER ID/POLICY #	EFFECTIVE DATE	RELATIONSHIP TO PATIENT	EMPLOYMENT STATUS

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	DATE OF BIRTH

ADDRESS & UNIT NUMBER IF APPLICABLE	CITY, STATE, ZIP CODE	SEX

GROUP #	MEMBER ID/POLICY #	EFFECTIVE DATE	RELATIONSHIP TO PATIENT	EMPLOYMENT STATUS

Emergency Contact

EMERGENCY CONTACT NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER

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