



# PATIENT REGISTRATION FORM

PATIENT INFORMATION				
PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN
MAIDEN NAME	NAME YOU GO BY			MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
STREET ADDRESS				APT. NO.
CITY	STATE	ZIP	HOME PHONE	
SOCIAL SECURITY NUMBER	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CELL PHONE	
EMPLOYER	OCCUPATION		WORK PHONE	
EMERGENCY CONTACT (NOT LIVING WITH YOU) / RELATION TO PATIENT			EMERGENCY CONTACT PHONE	

SPOUSE OR PARENT / RESPONSIBLE PARTY INFORMATION				
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other _____	
STREET ADDRESS			APT. NO.	HOME PHONE
CITY	STATE	ZIP	CELL PHONE	
SOCIAL SECURITY NO.			DATE OF BIRTH	
RESPONSIBLE PARTY EMPLOYER	OCCUPATION		RESPONSIBLE PARTY WORK PHONE/EXT.	

SECOND PARENT INFORMATION				
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other _____	
STREET ADDRESS			APT. NO.	HOME PHONE
CITY	STATE	ZIP	CELL PHONE	
SOCIAL SECURITY NO.			DATE OF BIRTH	
RESPONSIBLE PARTY EMPLOYER	OCCUPATION		RESPONSIBLE PARTY WORK PHONE/EXT.	

INSURANCE INFORMATION				
<b>PRIMARY</b>	INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)		GROUP NO.		
SUBSCRIBER		RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.	
<b>SECONDARY</b>	INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)		GROUP NO.		
SUBSCRIBER		RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.	

**HOW DID YOU HEAR ABOUT US?**

<input type="checkbox"/> Friend or relative <sup>1</sup>	<input type="checkbox"/> SSM referral line <sup>4</sup>	<input type="checkbox"/> Emergency room <sup>8</sup>
<input type="checkbox"/> Referred by another physician/ Dr. _____ <sup>2</sup>	<input type="checkbox"/> SSM website <sup>5</sup>	<input type="checkbox"/> Phone book <sup>9</sup>
<input type="checkbox"/> Insurance provider list <sup>3</sup>	<input type="checkbox"/> Newspaper <sup>6</sup>	<input type="checkbox"/> Community event or lecture <sup>10</sup>
	<input type="checkbox"/> Direct mail to your home <sup>7</sup>	<input type="checkbox"/> Other _____ <sup>11</sup>

**Insurance Payment Authorization and Release:** I hereby authorize my insurance benefits to be paid directly to the DePaul Medical Group, St. Charles Clinic Medical Group or SSM Medical Group and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

**Authorized signature** \_\_\_\_\_ **Date** \_\_\_\_\_