



PATIENT REGISTRATION

Patient's Name: First: _____ Middle: _____ Last: _____
Birth date: ____ / ____ / ____ Sex: M / F Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ How did you hear about us? _____
Preferred Contact By: Phone Email Letter Preferred Language: English Spanish Other: _____
Race: (1) Caucasian (2) Hispanic (3) African American (4) Other: _____
Ethnicity: (1) Hispanic or Latino (2) Non-Hispanic or Latino (3) Other: _____

EMERGENCY CONTACT

Name: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Relationship to Patient _____

PERSON RESPONSIBLE FOR BILL

Name: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Relationship: Self / Spouse / Child / Other: _____ Birth date: ____ / ____ / ____ Sex: M / F

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group: _____
Policyholder's Name (Person who carries insurance): _____ Birthdate: ____ / ____ / ____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Patient's Relation to Policyholder: Self / Spouse / Child / Other: _____
Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group: _____
Policyholder's Name (Person who carries insurance): _____ Birthdate: ____ / ____ / ____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Patient's Relation to Policyholder: Self / Spouse / Child / Other: _____
Employer: _____

I, the undersigned, assign directly to Family Medicine for McHenry County all benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signed _____ Date ____ / ____ / ____

Your insurance card and copayment are due at each visit. Please notify the office of any changes.