INTERNAL MEDICINE & FAMILY PRACTICE, S.C.
1719 GLENWOOD AVENUE
JOLIET, IL 60435

PATIENT INFORMATION

NAME: _____ S/S #: _____ DOB: _____ SEX: ☐M ☐F
LAST FIRST MI

ADDRESS: _____ PREFERRED CONTACT#: _____

CITY/STATE: _____ ZIP: _____ SECONDARY PHONE #: _____

E-MAIL ADDRESS: _____

ETHNICITY & RACE: _____ PRIMARY LANGUAGE: _____ SECONDARY: _____

DRIVER'S LICENSE/STATE ID#: _____

PRIMARY INSURANCE

INSURANCE POLICY HOLDER NAME: _____ RELATION: _____
BIRTHDATE: _____ POLICYHOLDER S/S NUMBER: _____
ADDRESS: _____ PHONE #: _____
CITY/ STATE: _____ ZIP: _____
INSURANCE COMPANY: _____
ID #: _____ GROUP #: _____
POLICYHOLDER EMPLOYER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE:

INSURANCE POLICY HOLDER NAME: _____ RELATION: _____
BIRTHDATE: _____ POLICYHOLDER S/S NUMBER: _____
ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP: _____
INSURANCE COMPANY: _____
ID #: _____ GROUP #: _____
POLICYHOLDER EMPLOYER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ASSIGNMENT AND RELEASE:

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO INTERNAL MEDICINE & FAMILY PRACTICE, SC ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

THE ABOVE-NAMED PHYSICIAN MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFTIS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE

_____ _____
PRINT NAME OF RESPONSIBLE PARTY RELATIONSHIP