Print Form

ILLINOIS UROLOGICAL INSTITUTE, S.C.

Please print this completed form and bring it to your appointment or you may fax it to (630) 690-6482

Patient Information

Name: _____ Account Number: _____

Social Security Number _____ Appointment Date: _____

Street Address: _____

City _____ State: _____ Zip: _____

Date of Birth: _____ ◯ Male ◯ Female Home Phone Number: _____

Email Address: _____ Cell Phone Number: _____

◯ Married ◯ Single ◯ Divorced ◯ Widowed Driver's License Number _____

Primary Care Physician: _____ PCP Phone Number: _____

What is the reason for your appointment? _____

Who can we thank for referring you to our doctors? _____

Emergency Contact Person & Relation: _____ Emergency Contact Number: _____

Patient's Employer: _____ Work Phone Number: _____

Patient Employer Address: _____

May we send you confirmation reminders of appointment dates to your email address? ◯ Yes ◯ No

Who is responsible for the payment of this account? _____

Financial/ Insurance Information

Primary Insurance Company: _____

Policy Holder: _____

Relation to Patient: _____

Date of Birth: _____

SSN _____

Employer: _____

Employer Address: _____

Group # _____ Subscriber# _____

Secondary Insurance Company _____

Policy Holder: _____

Relation to Patient: _____

Date of Birth: _____

SSN _____

Employer:: _____

Employer Address: _____

Group # _____ Subscriber# _____

Assignment of Benefits

I assign payment of authorized benefits to the physician on my behalf for medical services rendered. I understand that I am financially responsible for charges not covered by my insurance policy(ies) and agree to assume all collection costs for the balance should my account be placed into collections. Furthermore, I authorize the physician to release any medical information requested by my insurance company in order to process health insurance claims.

Signature _____ Date _____