HEALING MEDICAL GROUP

516 E Boughton RD, Bolingbrook, IL 60440
Phone: (630)400-4194 Fax: (863)546-4016

PATIENT REGISTRATION FORM

Today's Date: / /

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):		Birth date: / /	Sex: ❑ M ❑ F
Social Security no.:	Home phone: ( )	Cell Phone: ( )			
Can we send you General text Messages on above cell phone (eg, appointments reminder, request to call back)? ❑ Yes ❑ No					
Street address:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Guarantor (Insured individual)	Birth date: / /	Address (if different):	Home phone no.: ( )		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Primary Insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY

Name of local friend or relative / Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Healing medical group or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*