Addison Medical Associates, Ltd.
Medical Square
"Complete One-Stop Medical Care"
276 W. Fullerton Ave., Addison, IL 60101

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Marital status (circle one) Single / Married / Divorced / Separated / Widowed	Birth date: / /	Age:	Gender: ❑ M ❑ F

Social Security no.:	Home phone no.: ( )	Cell phone no.: ( )	Email Address:

Street address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ HMO	❑ PPO	❑ Worker's Compensation	❑ Medicare	❑ Medicaid	❑Other

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

Contact person:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize payment of medical benefits to myself or the above named provider for professional services rendered. I understand that I am financially responsible for any balance. I also authorize Addison Medical Associates, Ltd. or the insurance company to release any information required to process my claims. I also have received a copy of this office's Notice of Privacy Practices (HIPAA)

Patient/Guardian signature *Date*

Member Guarantee Form

I _____, hereby certify that I am eligible for
(Member name)

Health Plan Coverage with _____
(Insurance provider)

as of _____ through _____.
(Date) (Employer name)

I hereby certify that my Primary Care Physician is Dr. _____.

I understand that if the above is not true or if I am not currently eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all the services received within 30 days from the date of service.

_____ _____
Signature Of Member Or Guardian Signature Of Physician Office Staff

_____ _____
Print Name Of Member Date