OSF MEDICAL GROUP

TODAY'S DATE: _____

MRN: _____ (office use only)

PATIENT INFORMATION (PLEASE PRINT)

NAME: _____ _____ _____
(last) (first) (mi)

SOCIAL SECURITY NUMBER: _____ - _____ - _____

ADDRESS: _____

_____

CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: (_____) _____

CELL PHONE: (_____) _____

EMAIL ADDRESS: _____

WHO IS THE PATIENT'S PHYSICIAN? _____
(Primary Care)

DATE OF BIRTH: _____/_____/_____
(Month) (Day) (Year)

SEX: ❑ Male ❑ Female

MARITAL STATUS:
❑ Single ❑ Married ❑ Divorced
❑ Separated ❑ Widowed

ETHNICITY: (for medical statistical use only)
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Unknown(all with check boxes)

RACE:
❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Pacific Islander
❑ White or Caucasian
❑ Other: _____
❑ Unknown

LANGUAGE SPOKEN: _____ RELIGION: _____ PLACE OF WORSHIP: _____

EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____) _____ EXT: _____

EMPLOYMENT STATUS: ❑ Full-time ❑ Retired ❑ Active Military Duty ❑ Non-Employed
❑ Part-time ❑ Self-Employed ❑ Unknown
❑ Student Full Time ❑ Student Part Time

GUARANTOR INFORMATION

WHO IS RESPONSIBLE FOR THIS GUARANTOR ACCOUNT? ❑ Self ❑ Mother ❑ Father ❑ Spouse
❑ Other: _____

NAME: _____ _____ _____
(last) (first) (mi)

DATE OF BIRTH: _____/_____/_____
(Month) (Day) (Year)

SOCIAL SECURITY NUMBER: _____ - _____ - _____

SEX: ❑ Male ❑ Female

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____ HOME PHONE: (_____) _____

GUARANTOR EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

WORK PHONE: (_____) _____ EXT: _____

EMPLOYMENT STATUS:
❑ Full-time ❑ Part-time
❑ Retired ❑ Self-Employed
❑ Active Military Duty ❑ Unknown
❑ Non-Employed
❑ Student Full Time
❑ Student Part Time

(OVER PLEASE)

EMERGENCY / OTHER CONTACT INFORMATION

PATIENT'S SPOUSE NAME: _____ (last) _____ (first) _____ (mi)

SPOUSE PHONE: (_____) _____ EXT: _____

PATIENT'S CAREGIVER (if applicable): _____ (last) _____ (first) _____ (mi)

CAREGIVER PHONE: (_____) _____ EXT: _____

EMERGENCY CONTACT NAME: _____ (last) _____ (first) _____ (mi)

EMERGENCY CONTACT RELATIONSHIP TO PATIENT: ❑ Friend ❑ Relative ❑ Neighbor ❑ Caregiver ❑ Spouse

☎ EMERGENCY WORK PHONE NUMBER: (_____) _____ EXT: _____

☎ EMERGENCY CELL PHONE NUMBER: (_____) _____ EXT: _____

PATIENT INSURANCE INFORMATION (Please provide a copy of your insurance card(s) to the receptionist)

❶ PRIMARY INSURANCE NAME: _____
(SUCH AS: MEDICARE, MEDICAID OR COMMERCIAL INSURANCE NAME)

ADDRESS: _____

CITY: _____ STATE: ___ ZIP: _____ PHONE: (_____) _____ EXT: _____

POLICY #, MEDICARE #, OR MEDICAID #: _____ GROUP/CERTIFICATE #: _____

SUBSCRIBER NAME (if different): _____ SUBSCRIBER SEX: ❑ M ❑ F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COPAY: _____

SUBSCRIBER DATE OF BIRTH: ___/___/___ (Month) (Day) (Year)

RELATIONSHIP TO INSURED: ❑ Child ❑ Spouse ❑ Self ❑ Other _____

❷ SECONDARY INSURANCE NAME: _____
(SUCH AS: MEDICARE, MEDICAID OR COMMERCIAL INSURANCE NAME)

ADDRESS: _____

CITY: _____ STATE: ___ ZIP: _____ PHONE: (_____) _____ EXT: _____

POLICY #, MEDICARE #, OR MEDICAID #: _____ GROUP/CERTIFICATE #: _____

SUBSCRIBER NAME (if different): _____ SUBSCRIBER SEX: ❑ M ❑ F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COPAY: _____

SUBSCRIBER DATE OF BIRTH: ___/___/___ (Month) (Day) (Year)

RELATIONSHIP TO INSURED: ❑ Child ❑ Spouse ❑ Self ❑ Other _____

Thank you for choosing OSF MEDICAL GROUP