

**DUPAGE HEALTH SPECIALISTS  
Medicare Patient Registration Form**

Name: \_\_\_\_\_  
                    First                    M.I.                    Last  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Birth Date: \_\_\_\_\_      *Soc. Sec. No.:* \_\_\_\_\_

Female: \_\_\_\_\_      Male: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_

1<sup>st</sup> Emergency Contact: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
2<sup>nd</sup> Emergency Contact (not living with you): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

**PRIMARY MEDICAL INSURANCE**

Insured's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_      Phone No.: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Carrier Name: \_\_\_\_\_

*Soc. Sec. No.:* \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Employer Insurance Plan?    **Y N**  
Phone No.: \_\_\_\_\_

**If insurance card is not available, please provide address, group/policy number, insurance ID number, copay amount**

Address: \_\_\_\_\_  
I.D. No.: \_\_\_\_\_      Group No.: \_\_\_\_\_      Copay Amount: \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE**

Insured's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_      Phone No.: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Carrier Name: \_\_\_\_\_

*Soc. Sec. No.:* \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Employer Insurance Plan?    **Y N**  
Phone No.: \_\_\_\_\_

**If insurance card is not available, please provide address, group/policy number, insurance ID number, copay amount**

Address: \_\_\_\_\_  
I.D. No.: \_\_\_\_\_      Group No.: \_\_\_\_\_      Copay Amount: \_\_\_\_\_

**CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS AND FINANCIAL AGREEMENT**

I hereby voluntarily consent to care encompassing routine diagnostic procedures and medical treatment authorized by physicians or other employee agents of DuPage Health Specialists. I request that payment of authorized Medicare benefits be made either to me or on my behalf to DuPage Health Specialists for any services furnished me by this physician group, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. I take full responsibility for charges not covered by my insurance plan.

I request that payment of authorized MediGap/Secondary Insurance benefits be made either to me or on my behalf to DuPage Health Specialists for any services furnished me by that physician group. I authorize any holder of medical information about me to release to MediGap/Secondary Insurance any information to determine these benefits or the benefits payable for related services.

I authorize payment of medical benefits to DuPage Health Specialists and its agents. I(We) absolutely and unconditionally guarantee payment for all amounts legally due for clinical services rendered to patient by DuPage Health Specialists. If my charges must be referred to a collection agency, I understand I will be charged a reasonable fee for collection agency costs and/or attorney fees. I take full responsibility for charges not covered by my insurance plan and for confirming my physician's participation with my insurance plan network. DuPage Health Specialists reserves the right to assess a surcharge if responsible party needs to be billed for copay.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Medicare Number (HICN)