**DUPAGE HEALTH SPECIALISTS**
**Patient Registration**

Name: _____ Female: _____ Male: _____
First M.I. Last
Home Phone: _____
Street Address: _____ Work Phone: _____
City/State/Zip: _____ Cell Phone: _____
Birth Date: _____ ***Soc. Sec. No.:*** _____ Occupation: _____
How did you hear about us? _____ Employer: _____

1st Emergency Contact: _____ Home Phone: _____
Relationship to Patient: _____ Work Phone: _____
2nd Emergency Contact (not living with you): _____ Home Phone: _____
Relationship to Patient: _____ Work Phone: _____

## RESPONSIBLE PARTY/MEDICAL INSURANCE INFORMATION

Insured's Name: _____ ***Soc. Sec. No.:*** _____
Relation to Patient: _____ Birth Date: _____ Gender: **M F** Phone No.: _____
Employer: _____ Employer Insurance Plan? **Y N**
Carrier Name: _____ 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 COVERAGE

Insured's Name: _____ ***Soc. Sec. No.:*** _____
Relation to Patient: _____ Birth Date: _____ Gender: **M F** Phone No.: _____
Employer: _____ Employer Insurance Plan? **Y N**
Carrier Name: _____ 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 employees or agents of DuPage Health Specialists. I authorize any holder of medical or other information about me to release any information needed to process my insurance claims and permit a copy of this authorization to be used in place of the original. I also authorize, at my request, release of medical records. I authorize DuPage Health Specialists to release information during a claims appeal process to my insurance plan, the Illinois Attorney General and/or the Illinois Department of Insurance. 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. DuPage Health Specialists reserves the right to assess a surcharge if responsible party needs to be billed for copay.

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.

Because every employer negotiates different medical coverage for its employees, I understand DuPage Health Specialists can't know what services my insurance does or does not cover. Therefore, I take full responsibility for paying any charges not covered by my insurance company and for confirming my physician's participation with my insurance network.

_____ _____
Patient Signature Date

_____ _____
Signature of Guarantor/Relationship to Patient Date

**YEARLY UPDATE: I hereby certify the above information is correct, including my consent for treatment, release, assignments and financial agreement.**

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date