WESTERN SPRINGS FAMILY PRACTICE CENTER, LTD.
PATIENT INFORMATION

Name____ Date of Birth______________________________
First MI Last

Male_____Female_____Minor______Single_____Married_____Divorced_____Widowed_____

Address____City________________________State______Zip_______________

Home Phone______________________Cell Phone______________________Email____

Social Security No________________________Referred to us by____

Emergency Contact______________________________Phone____________________Relationship to patient______________

Patient Employer____ ____

Address____Phone__________________________________

INSURANCE INFORMATION

Policy Holder____Relationship to Patient__________________

Date of Birth_________________________________Social Security Number____________________________________

Employer____Phone__________________________

Employer Address____

Insurance Carrier____________________________ID No.______________________Group Number________________

Copay______________________________________Deductible_________________________________

SECONDARY INSURANCE - Please complete the following if you have secondary insurance

Policy Holder____Relationship to Patient__________________

Date of Birth_________________________________Social Security Number_____________________________________

Employer____Phone_________________________

Employee Address____

Insurance Carrier______________________________ID No.______________________Group Number______________

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign Western Springs Family Practice Center, Ltd. for all payments for medical services rendered. I acknowledge that I am responsible for payment of all charges incurred, unless I am an HMO, PPO or Medicare patient. In that instance, I am responsible for any deductible or copayments required by my particular plan or by Medicare.

____Date___________________________________
Patient Name (Printed)

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Patient Signature