

SURGICAL CONSULTANTS OF DUPAGE

908 N. Elm St., Hinsdale, IL 60521

(630) 325-3310 Office

(630) 325-9163 Fax

PATIENT INFORMATION

Name: _____

Patient ID #: _____ Sex: M F

Address: _____

Date of Birth: _____

City, State: _____

Social Security #: _____

Phone: _____ Home Work Cell

Marital Status: Married Single Divorced Widowed

Phone: _____ Home Work Cell

Referring Physician: _____

Primary Physician: _____

PATIENT EMPLOYMENT

Employed Retired Unemployed Other

Phone: _____

Employer: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Daytime Phone: _____

GUARANTOR/RESPONSIBLE PARTY

Same as Patient

Name: _____

Address: _____

City, State: _____

GUARANTOR/RESPONSIBLE PARTY EMPLOYER

Employer: _____

Phone: _____

Phone: _____

PRIMARY INSURANCE

Same as Patient Same as Guarantor Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

Same as Patient Same as Guarantor Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

AUTHORIZATIONS:

BENEFITS TO PHYSICIAN:

I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PHYSICIAN. I UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY MY INSURANCE COMPANY.

RELEASE OF INFORMATION:

I HEREBY AUTHORIZE RELEASE OF MY INFORMATION FOR INSURANCE CLAIM PURPOSES. I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. MY SIGNATURE INDICATES THAT I HAVE READ THE ABOVE AND GRANT THE REQUEST OF INFORMATION.

DATE ____/____/____

SIGNED _____

Patient, Guardian or Insured