Northern Illinois Medical Associates

Patient Registration

Demographics

Full Name: _____ **Date of Birth:** ____/____/____

First Middle Last

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____ *This is to activate your online patient portal*

Soc Sec# _____

May we leave messages on your voicemail? ___Yes ___No **Detailed messages OK** ___Yes___ No

Sex: ◯ M ◯ F **Date Of Birth:** ____/____/____ **Marital Status:** ___ **Veteran Status:** ___

Race: ◯ *Asian* ◯ *African American* ◯ *Caucasian* ◯ *Hispanic* ◯ *Other* _____

Ethnicity: ◯ *Hispanic/Latino* ◯ *Non-Hispanic/Latino* **Primary Language:** _____

Emergency Contact _____ Phone _____

Relationship: _____ Address: _____

Preferred Pharmacy Name/Address: _____

Are you new to our office? ___ **How did you hear about us?** _____

Is this visit related to a Work Injury or Motor Vehicle Accident? _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient: _____

Date of Birth ____/____/____ SS# _____ Primary Phone # _____

Address (if different from patient): _____

Employer: _____ Insurance Company Name: _____

Insurance Phone #: _____

Identification Number: _____ Group Number: _____

Do you have a Durable Power of Attorney? ___ Y/N If yes, Name: _____

Phone Number: _____ *If you need to assign one, we can provide a form.

Electronic Communication: *Our electronic medical records (EMR) allow for your vaccine history to be sent and retrieved directly form I-CARE through the State of Illinois. Our EMR also allows pharmacies to give us details on your prescription history. By signing here, you are authorizing this.*

Signature _____ Date ____/____/____

Patient/Parent/Guardian Relationship to Patient: _____

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Sycamore, IL 60178

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STE 100
Elgin, IL 60123

1000 S Randall Rd
STE 225
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