

PHYSICIANS OF THE NORTH SHORE, LTD.
9555 Gross Point Road, Skokie, IL 60076
1535 Lake Cook Road, Suite 612, Northbrook, IL 60062

PATIENT REGISTRATION FORM

Date: _____

Patient Information:

Patient Name: _____ Previous Patient: _____
(Last) (First) (MI) Date of Last Visit: _____

Address: _____ City: _____ State: _____ Zip Code _____

Marital Status: _____ Home Phone() _____ Work Phone: () _____

Male/Female: _____ Date of Birth: _____ Social Security #: _____

Spouse First Name: _____ Spouse's Date of Birth: _____ Spouse's SS N #: _____

Referred by: _____ Allergies: _____ Pharmacy: _____
(Name/Phone#)

Emergency

Contact Name: _____ Phone: () _____
(Last) (First) (MI)

Appointment Information

Reason for appointment: _____ Name of Doctor to see: _____

Was this an Accident?: _____ If so, where did the accident occur?: _____

Are you claiming W/C?: _____ W/C Verification: _____

(To be filled out by our office)

Insurance Information

1. Primary Insurance Company/Address/Phone: _____

Name of Insured: _____ Ind/Group Policy #: _____

Relationship to Patient: _____

2. Secondary Insurance Company/Address/Phone: _____

Name of Insured: _____ Ind/Group Policy #: _____

Relationship to Patient: _____

3. Additional Insurance Company/Address/Phone: _____

Name of Insured: _____ Ind/Group Policy #: _____

Relationship to Patient: _____

4. Are you in a HMO/PPO; if so, list: Name: _____ Address: _____
 Phone () _____ Ind/Group Policy #: _____ Name of Insured: _____
 Relationship to Patient: _____

5. If Name of Insured is other than patient or spouse, please list information:
 Named of Insured: _____ Address: _____ City: _____
 State: _____ Zip: _____ Date of Birth: _____ Social Security #: _____

Employment Information:

Patient's Employer:	_____		
	Company	Address	Phone
Wife's Employer:	_____		
	Company	Address	Phone
Husband's Employer:	_____		
	Company	Address	Phone

MEDICARE & MEDICAID

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries of carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare.

I request that payment under the medical insurance program be made to Physicians of the North Shore, LTD. (hereinafter referred to as Provider) on any bills for services furnished me by the Provider.

ALL OTHER INSURANCE

I hereby authorize Physicians of the North Shore, LTD. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered for all medical care by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services.

I authorize Provider to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

I hereby authorize the physicians of Provider to perform all treatment and procedures which they consider necessary or advisable for my benefit upon consultation with the patient or patient's parent or guardian.

I hereby agree to pay the regular charges of Provider for all treatment and procedures performed by Provider in the event that such charges not approved by Medicare/Medicaid or other insurance company or that less than the regular charges are reimbursed by Medicare/Medicaid or other insurance company.

 SIGNATURE _____
 DATE