Midwest Allergy Inc

1425 N McLean Blvd - Ste 100
Elgin, IL 60123
(847) 931-1999

10001 W. Roosevelt Rd. - Ste 304
Westchester, IL 60154
(708) 344-3550

7808 College Drive
Palos Heights, IL 60643
(708) 361-0730

REGISTRATION FORM

(Please print clearly)

PATIENT INFORMATION Date: _____

Name: _____ Social security #: _____
Last First MI

Address: _____ Home phone: (_____) _____

City: _____ State: _____ Zip: _____ Cell phone: (_____) _____

Birthdate: _____/_____/_____ Sex: ☐ Male ☐ Female E-mail: _____

Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partnered ☐ Minor /Child

Preferred Language: ☐ English ☐ Spanish ☐ Other Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race: ☐ Asian ☐ Black/African American ☐ European American ☐ Native Hawaiian
☐ Native American ☐ Pacific Islander ☐ White

Spouse/parent name _____ Spouse/Parent Birthday: ____/____/___

Patient Employer/School: _____ Occupation: _____

Employer/School address: _____Work/school phone: (_____) _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified?_____ Relation: _____

Address: _____ Phone: (_____)_____

PRIMARY INSURANCE

Person responsible for Account: _____

Relation to patient: _____ Birthdate: _____/_____/_____ SSN: _____

Address (if different than patient's):_____ Home phone: (____) _____

Person responsible employed by: _____ Occupation: _____

Business address: _____ Business tel: (____) _____

Insurance Company: _____

Group number: _____ Patient's ID number: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance: ☐ yes ☐ no If yes, complete the following:

Name of insured: _____

Relation to patient: _____ Birthdate: _____/_____/_____ SSN: _____

Address (if different than patient's):_____ Home phone: (____) _____

Person responsible employed by: _____ Occupation: _____

Business address: _____ Business tel: (____) _____

Insurance Company: _____

Group number: _____ Patient's ID number: _____

I do hereby consent to treatment by Allergy and CI Immunology Center and it's associated providers for myself/my minor child. I further authorize Allergy and CI Immunology Center and its associated providers to release to my insurance companies any information, including diagnosis and record of treatment or examination which was rendered to me/my minor child. I also authorize payment directly to the treating physician of any surgical/medical benefits, otherwise payable to me, for services that he and/or his associates rendered. I do understand that I am financially responsible for all charges whether or not paid by the insurance, and that I am responsible for the settlement of any dispute regarding benefits due from my insurance company. I also understand that if I allow payment of this account to become delinquent, that my account may be turned over to an outside agent for collection. In that case, I will be responsible for any and all collection fees, attorney fees and court costs in addition to my original balance due.

SIGNATURE OF PATIENT/INSURED (Parent for minor child) _____