



**OSF**<sup>®</sup>  
MEDICAL GROUP

TODAY'S DATE: \_\_\_\_\_

MRN: \_\_\_\_\_ (office use only)

**PATIENT INFORMATION (PLEASE PRINT)**

NAME: \_\_\_\_\_  
(last) (first) (mi)

DATE OF BIRTH: \_\_\_\_\_  
(Month) (Day) (Year)

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SEX:  Male  Female

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

MARITAL STATUS:  
 Single  Married  Divorced  
 Separated  Widowed

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ETHNIC GROUP: (for medical statistical use only)  
 White (not of Hispanic origin)  
 Black (not of Hispanic origin)  
 Asian or Pacific Islander  
 American Indian or Alaskan Native  
 Hispanic  
 Other

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_

WHO IS THE PATIENT'S PHYSICIAN? \_\_\_\_\_  
(Primary Care)

**EMPLOYMENT INFORMATION**

PATIENT EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYMENT STATUS:  Full-time  Retired  Active Military Duty  Non-Employed  
 Part-time  Self-Employed  Unknown

**GUARANTOR INFORMATION**

PATIENT'S RELATIONSHIP TO GUARANTOR:  Self  Child  Spouse  Other: \_\_\_\_\_

NAME: \_\_\_\_\_  
(last) (first) (mi)

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_

GUARANTOR EMPLOYER: \_\_\_\_\_

EMPLOYMENT STATUS:  
 Full-time  Part-time  
 Retired  Self-Employed  
 Active Military Duty  Unknown  
 Non-Employed

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

**(OVER, PLEASE)**

**EMERGENCY / OTHER CONTACT INFORMATION**

PATIENT'S SPOUSE NAME: \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi)

SPOUSE EMPLOYER: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

PATIENT'S CAREGIVER (if applicable): \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi)

CAREGIVER PHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

EMERGENCY CONTACT NAME (if other than spouse or caregiver): \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi)

EMERGENCY CONTACT RELATIONSHIP TO PATIENT:  Friend  Relative  Neighbor  Caregiver

☎ DAYTIME EMERGENCY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

☎ EVENING EMERGENCY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

**PATIENT INSURANCE INFORMATION**

(Please provide a copy of your insurance card(s) to the receptionist)

❶ PRIMARY INSURANCE NAME: \_\_\_\_\_ (SUCH AS: MEDICARE, MEDICAID OR COMMERCIAL INSURANCE NAME)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

POLICY #, MEDICARE #, OR MEDICAID #: \_\_\_\_\_ GROUP/CERTIFICATE #: \_\_\_\_\_

INSURED NAME (if different): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COPAY: \_\_\_\_\_

RELATIONSHIP TO INSURED:  Child  Spouse  Self  Other \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Month) (Day) (Year)

❷ SECONDARY INSURANCE NAME: \_\_\_\_\_ (SUCH AS: MEDICARE, MEDICAID OR COMMERCIAL INSURANCE NAME)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

POLICY #, MEDICARE #, OR MEDICAID #: \_\_\_\_\_ GROUP/CERTIFICATE #: \_\_\_\_\_

INSURED NAME (if different): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COPAY: \_\_\_\_\_

RELATIONSHIP TO INSURED:  Child  Spouse  Self  Other \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Month) (Day) (Year)

Thank you for choosing OSF MEDICAL GROUP