



OSF[®]
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 YOUR 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

(Individual responsible for payment . . .if SELF, go to next page)

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