Northern Illinois Medical Associates
PATIENT REGISTRATION FORM

(Please complete all questions)

Today's Date: _____

Patient Name: _____ **Soc Sec#:** _____
Last First Middle Initial

Address: _____

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

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

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

May we leave messages on your voicemail? _____ Yes, Detailed Message OK _____ Yes, No Details _____ No

Sex: _____M _____F **Date of Birth**: _____ **Marital Status:** _____ __**Veteran Status:** _____

Race: _____ Asian _____ African American/Black _____Caucasian/White _____ Hispanic _____Other_____

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

In case of emergency who should we contact? _____ Relationship:_____

Address: _____ Telephone:_____

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

Person Responsible for Insurance: _____Relationship to Patient: _____

Date of Birth: _____ Soc Sec#:_____ Primary Phone # _____

Address (if different from patient):_____

Employer: _____ Insurance Company Name: _____

Insurance Phone #: _____

Identification Number: _____ Group Number: _____

Is this patient covered by another Insurance? _____

Person responsible for Secondary Insurance: _____ Date of Birth: _____

Name of Secondary Insurance: _____ Insurance Phone #: _____

Identification Number: _____ Group Number: _____

Do you have a Durable Power of Attorney? _____ If yes, Name: _____

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

Immunizations: *Our electronic medical records system allows for your vaccine history to be sent directly to I-CARE through the state of Illinois. I-CARE allows your providers to obtain your vaccine history to ensure your safety. By signing here, you are authorizing us to submit this data.*

Signature: _____ **Date:** _____
Patient/Parent/Guardian Relationship to Patient

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND PHOTO ID. THANK YOU!