

**OAKBROOK TERRACE DERMATOLOGY ASSOCIATES
PATIENT REGISTRATION FORM 2010**

Thank you for choosing our office. We will do our best to serve your medical needs. Please complete this form in full. All of your information will be kept strictly confidential.

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status:		
<input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone: ()			
City:		State:		Zip Code		Other phone:		
Email Address:		Other family members seen here:			Work/Cell phone: ()			
How were you referred to our practice? (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	(please indicate)			
Patient current medications:								

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Person Responsible for this account:		Birth date:	Address (if different):		Home phone no.: ()	
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
S.S. #:	Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Please indicate primary insurance		<input type="checkbox"/> Blue Cross/ Blue Shield PPO	<input type="checkbox"/> First Health Affordable	<input type="checkbox"/> Medicare	<input type="checkbox"/> Self pay	<input type="checkbox"/> Other
Policy Holder's name:		Policy Holder SS#:	Birth date:	Policy Id: (if card is not present)	Group: (if card is not present)	Co-payment: \$
Patient's relationship to Insured:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

PATIENT AGREEMENT

May we leave messages on your voicemail regarding appointments or test results? (if no please notify receptionist)		Preferred method of contact:	Primary phone number: ()	May we add you to our monthly newsletter for specials and skin info? <input type="checkbox"/> Yes <input type="checkbox"/> No
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician if I have BCBS PPO, First Health Affordable or Medicare. I understand that I am financially responsible for any balance. I also authorize Dr. Keuer and Dr. Allen or another insurance company to release any information required to process my claims. As our patient, your signature is required to indicate acceptance of our office policies.

Patient/Guardian signature _____ Date _____