

Patient Registration - Adult

DuPage Medical Group

WE CARE FOR YOU

PHYSICIAN NAME	DATE
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Patient Information (please print)

PATIENT NAME (LAST, FIRST MIDDLE)		SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	MAIDEN NAME
ADDRESS	UNIT #	CITY, STATE, ZIP CODE		COUNTY	PRIMARY LANGUAGE
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	HOME PHONE #	CELL/PAGER #	MAY WE CONTACT YOU BY EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMAIL ADDRESS
EMPLOYER (IF RETIRED, PLEASE INDICATE HERE)	WORK PHONE # ()	EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		RACE CODE	ETHNICITY CODE

Emergency Contact 1 **Emergency Contact 2**

EMERGENCY CONTACT NAME	RELATIONSHIP <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> FRIEND <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	EMERGENCY CONTACT NAME	RELATIONSHIP <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> FRIEND <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER
HOME TELEPHONE NUMBER ()		HOME TELEPHONE NUMBER ()	
WORK TELEPHONE NUMBER ()		WORK TELEPHONE NUMBER ()	
CELL/MOBILE TELEPHONE NUMBER ()		CELL/MOBILE TELEPHONE NUMBER ()	

Account Guarantor *If the Patient and the Account Guarantor are the Same- Please proceed to the Insurance Section*

GUARANTOR OF ACCOUNT (RESPONSIBLE PARTY)		RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE	<input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	SOCIAL SECURITY NUMBER
ADDRESS	UNIT #	CITY, STATE, ZIP CODE		COUNTY
DATE OF BIRTH				
SEX <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYER (IF RETIRED, PLEASE INDICATE HERE)	HOME PHONE # ()	WORK PHONE # ()	CELL / PAGER PHONE # ()

Primary and Secondary Insurance *(attach copy of the front and back of insurance cards)*

PRIMARY INSURANCE COMPANY NAME		SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID/POLICY #	COPAY	EFFECTIVE DATE	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT
					<input type="checkbox"/> SELF <input type="checkbox"/> OTHER
SECONDARY INSURANCE COMPANY NAME		SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID/POLICY #	COPAY	EFFECTIVE DATE	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT
					<input type="checkbox"/> SELF <input type="checkbox"/> OTHER

<i>I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.</i>	Authorization for Release of Information	
	I authorize DUPAGE MEDICAL GROUP to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify DUPAGE MEDICAL GROUP in writing of any information I do not want released.	
	SIGNATURE	DATE

Assignment of Benefits

I authorize the assignment of benefits payable to DUPAGE MEDICAL GROUP and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

Authorization for Additional Fees

In the event any lawsuit of action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional cost that this action may incur.

Authorization for Treatment

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

SIGNATURE	DATE
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At DuPage Medical Group (DMG), we are united with one common goal – to care for you and your family. As part of this goal, DMG is focused on meeting Meaningful Use objectives to improve clinical quality and patient outcomes. “Meaningful Use” is a government program to ensure that healthcare professionals are utilizing their Electronic Medical Record (EMR) system efficiently to improve healthcare quality and patient safety.

A core Meaningful Use objective is to record patient demographics: preferred language, gender, race, ethnicity, and date of birth. The Race and Ethnicity categories below are defined by the Federal Office of Management and Budget (OMB) and the United States Census Bureau.

Please use the lists below when indicating your Race and Ethnicity:

RACE

- R1** - American Indian or Alaska Native
- R2** - Asian
- R3** - Black or African American
- R4** - Native Hawaiian or Pacific Islander
- R5** - White
- R9** - Other

ETHNICITY

- 1** - Hispanic or Latino ethnicity
- 2** - Non-Hispanic or Latino ethnicity

DuPage Medical Group understands that this is very personal and sensitive information. We want to assure you that this information will only be used as part of the Meaningful Use objectives.

