LAKE COOK ORTHOPEDICS

REGISTRATION FORM

_____ _M or F_____

Patient Last Name First Name Middle Sex (Circle)

_____ S M D W O

Social security # Date of birth Age Marital Status (Circle)

_____

Address Apt # (if applicable) City State Zip Code

(_____)_____(_____)_____

Home phone # Cell phone # Email address (used for patient portal) Referring physician

_____(_____)_____

Employer Employer address Occupation Business phone #

_____(_____)_____

Emergency Contact name Emergency contact phone # Relationship to patient

Primary Race (circle one): Caucasian African-American Asian American Indian Native Hawaiian unknown

Ethnicity (circle one): Hispanic Non-Hispanic unknown

Preferred language (circle one): English Spanish Other _____

MEDICAL INSURANCE INFORMATION (MUST COMPLETE EVEN IF INSURANCE CARD PRESENTED)

Primary insurance company name: _____ Phone#_____

Policy holder Name: _____Date of birth_____ Social Security # _____

Relationship to patient _____ ID #_____ Group # _____

Secondary insurance company name: _____Phone#_____

Policy holder Name: _____Date of birth_____ Social Security # _____

Relationship to patient _____ ID #_____ Group # _____

GUARANTOR INFORMATION (APPLICABLE IF PATIENT IS A MINOR)

_____

Guarantor Last Name First Name Middle Social security # Date of birth

_____

Address Apt # (if applicable) City State Zip Code

(_____)_____(_____)_____

Home phone # Cell phone # Relationship to patient

_____(_____)_____

Employer Employer address Business phone #

RELEASE & ASSIGNMENT: I authorize any holder of medical or other information about me to release any information needed to process my insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to the undersigned provider(s).

Signature: _____ Date: _____

(patient, parent or legal guardian)