OSF HEALTHCARE

REGISTRATION FORM

Acct #:
Provider:

Patient Information

Social Security #	Full Name: Last	First	Middle	Maiden (Other)

Address: Street or Rural Route	City	State	Zip Code

Home Phone #	Work Phone #	Extension	Cell Phone #

Date of Birth	Age	Marital Status Single Married Widowed Divorced	Sex (circle one) Female Male	Spouse's Name

Reason for Visit	Patient's Primary Care Physician and Phone #

Patient Additional Information:	
Can messages be left on voicemail? Home: Y / N Work: Y / N Cell: Y / N	Emergency contact for patient:
Information can be released to the following person(s) (include date of birth)	Name: Phone: Relationship:
Patient's email address:	Living Will: Y / N / Power of Attorney Y / N

PATIENT CURRENT EMPLOYMENT INFORMATION

Occupation	Employer	Employer Address

If Student Indicate School	If Patient is a Minor, provide Name of Parent(s)) or Legal Guardian (legal documentation required):

RESPONSIBLE PARTY ☐ Please check box if Responsible Party is the same as the Patient.

Social Security #	Full Name: Last	First	Middle	Maiden (Other)

Address: Street or Rural Route P.O. Box	City	State	Zip

Home Phone #	Work Phone #	Extension	Email Address

Date of Birth	Age	Sex (cirlce one) Female Male	Relationship to Patient

Responsible Party Employer	Responsible Party Employer Address

INSURANCE INFORMATION Please provide copy of your insurance card to front office respresentative.

Name of Primary Insurance Company		Name of Secondary Insurance Company	
Subscriber (Policyholder if not patient)	Date of Birth	Subscriber (Policyholder, if not patient)	Date of Birth
Subscriber Address, City, State, & Zip		Subscriber Address, City, State, & Zip	
Social Security #	Relationship to Patient	Social Security #	Relationship to Patient

Revised: 04/21/10 jmk

Is this visit due to an accident? Y N	**Date of Accident/On-set:**
If yes, is the accident an (circle one) Auto Accident Work Injury Other **Explain other:**	
Employer Name	**Phone #** **( )**
Mailing Address City State Zip	
Work Company Carrier Name	
Is this visit for a pre-employment exam? Y N	**If yes, please complete**
Potential Employer Name	**Phone #** **( )**
Mailing Address City State Zip	

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

X Signature of Patient, Parent or Legal Guardian Date

If patient is a minor:

My signature authorizes evaluation and treatment for my child and also authorizes consent to medical and surgical procedures and immunizations for the child named herein _____ (Name of Child).

Financial Responsibility / Medical Information Release

I hereby authorize payment of medical benefits directly to BroMenn Physicians Management Corporation, DBA BroMenn Medical Group and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim and/or for the purpose of determining eligibility of employment. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), Drug Screen and Breath Alcohol Testing. **I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies and/or employer. I agree that all amounts are due upon request and are payable to BroMenn Medical Group. I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of BroMenn Medical Group, if any.**

X Signature of Patient, Parent or Legal Guardian Date

FOR OFFICE USE ONLY:

Copy of insurance card obtained and scanned _____ *Initials*

Current insurance verified and already on file _____ *Initials*

Patient's demographics verified and updated _____ *Initials*

Photo ID verified for new patients and/or per practice specific policy _____ Initials