Patient Registration Form

THE MEDICAL GROUP
OF KANKAKEE COUNTY

Patient Information

Last Name: _____ First Name: _____Middle: _____

Birth/Maiden Name: _____

Birth Sex: ☐ Male ☐ Female Social Security Number: ____ – ____ – _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Date of Birth: ____ / ____ / _____

Race: _____ Ethnic Group: _____Preferred Language: _____
Ex: White, Black, Asian Ex: Latino, Jewish, Italian

Address

Street Address: _____Apt _____

City: _____ State: ____ Zip: _____

Patient Contact Information

Phone (Home): (____) _____Phone (Cell): (____) _____
Permission to contact you by Phone ☐ YES ☐ NO
Permission to leave detailed message ☐ YES ☐ NO
Email: _____
☐ I would like to create a Patient Portal Account ☐ I already have a Patient Portal Account

Guarantor Information

Guarantors Information / ***Person Responsible for Bill – If different than above*.**

Last Name: _____ First Name: _____

DOB: _____ Social Security Number: _____

Cell Phone: (____)_____ Work Phone: (____)_____

Home Phone: (____)_____ Relationship to Patient: _____

Insurance

Primary Insurance Name: _____

Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____

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Secondary Insurance Name: _____

Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____

Primary Emergency Contact Information

Last Name: _____First Name: _____

Home Phone: (____) _____ Work/Office Phone: (____) _____

Cell Phone: (____) _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Friend ☐ Other: _____

May we discuss your health issues with this person? ☐ YES ☐ NO

Additional Emergency Contact:

Last Name: _____First Name: _____

Home Phone: (_____) _____ Work/Office Phone: (_____) _____

Cell Phone: (_____) _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Friend ☐ Other: _____

May we discuss your health issues with this person? ☐ YES ☐ NO

Acknowledgements

This information may be changed or revoked by filing out a new request or revoking this one in writing.

Test Results & Communication Notice:

Test results are usually available within **3-5 business days** after completion. Our office will contact you only for tests we order; for outside tests, please call the ordering provider. If you do not hear from us after 5 days, please call our office.

Notice of Privacy Practices

I acknowledge receipt of The Medical Group of Kankakee County's notice of Privacy Practices. I understand that The Medical Group of Kankakee County has reserved the right to change the privacy practices that are described in the notice. I also understand that a copy of the notice will be available to me at my next visit to the practice.

Payment of Benefits and Assignment and Release of Information

I direct payment to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize release of any information relating to my treatment for insurance purposes. I authorize the use of this signature on all insurance or other health care providers' submissions.

Patient / Responsible Party Signature: _____

Relationship to Patient: _____

Date: ____ / ____ / _____