EXHALE SINUS
TMJ | HEADACHE | SLEEP

814 E. Woodfield Rd.
Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332

PATIENT REGISTRATION

PATIENT'S INFORMATION

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. LAST NAME FIRST NAME MIDDLE

LEGAL GENDER PER INSURANCE ☐ Male ☐ Female | GENDER IDENTITY ☐ Cis-Gender ☐ Gender Fluid ☐ Non-Gender ☐ Trans-Gender | ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SOCIAL SECURITY # DATE OF BIRTH: PHONE #: EMAIL ADDRESS:

HOME ADDRESS: APT #: CITY: STATE: ZIP:

EMPLOYER: CITY: STATE: ZIP:

EMERGENCY CONTACT PERSON(S): CONTACT #: RELATION:

PREFERRED COMMUNICATION: ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ MAIL

INSURANCE INFORMATION

	PRIMARY INSURANCE	***SECONDARY INSURANCE***
POLICY HOLDER'S NAME:		
INSURANCE CO.:		
POLICY #:		
GROUP NAME #:		

**IF THE PERSON INSURED IS DIFFERENT FROM THE GUARANTOR, PLEASE PROVIDE THE INFORMATION BELOW SO WE CAN ASSIST YOU IN FILING YOUR MEDICAL CLAIM.*

GUARANTOR INFORMATION (Person who pays for the insurance policy / Insurance holder)

NAME: RELATIONSHIP: DOB: SSN:

HOME ADDRESS: APT #: CITY: STATE: ZIP:

EMPLOYER: CITY: STATE: ZIP:

OCCUPATION: CELL # WORK # EMAIL:

☐ I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. I RELEASE YOU FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED.

☐ I DO NOT AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. IN DOING SO I AM RESPONSIBLE FOR MY MEDICAL BILLS.

Signature of Patient/Legally Authorized Representative

Date