## CHICAGO HEALTH MEDICAL GROUP PATIENT INFORMATION

TODAY'S DATE:

PATIENT NAME: \_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_ MALE \_\_ FEMALE \_\_ (MIDDLE INT) MARITAL STATUS: SINGLE ADDRESS: \_\_\_\_\_ MARRIED OTHER (WIDOW, DIVORCE, SEPARTED) CITY) (STATE) (ZIP CODE) RACE: (check one) \_\_American Indian/Alaska Native \_\_Middle Eastern/North African \_\_Asian/Oriental SS#: White Black/African American Other ETHNICITY: (check one) \_\_Central American Mexican CELL PHONE: Cuban Not Hispanic or Latino Puerto Rican Dominican EXT: WORK PHONE: \_\_\_ Hispanic/Latino/Spanish South American Latin American Spaniard CONTACT PREFERENCE: Other \_\_ Home Phone Cell/Mobile Work Phone Mail IS INJURY RELATED TO: (check one) PRIMARY CARE PHYSICIAN: \_\_\_\_\_ WORK AUTO ACCIDENT \_\_\_\_ OTHER \_\_\_ EMPLOYER: DATE OF INJURY: EMPLOYER ADDRESS: \_\_\_\_\_ LAST DAY WORKED: \_\_\_ (CITY) (STATE) (ZIP CODE) \_\_\_\_\_SPOUSE WORK PHONE: \_\_\_\_\_\_ EXT: \_\_\_\_\_ EMERGENCY CONTACT: \_\_\_\_\_ (Relationship): (PHONE - DIFFERENT FROM ABOVE) (NAME) DO YOU HAVE AN ADVANCE DIRECTIVE? (LIVING WILL/POWER OF ATTORNEY) If yes, please provide for our records. no ves F ATTORNEY) yes\_\_ no\_\_ If yes, please provide for PATIENTS RIGHTS AND RESPONSIBILITIES PROVIDED \_ ADVANCE DIRECTIVE INFORMATION PROVIDED \_\_\_\_\_ OFFICE STAFF INITIALS OFFICE STAFF INITIALS POLICY HOLDER INFORMATION (Please complete, if different from patient information) POLICY HOLDER NAME DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_ OR WORKMAN'S COMP: (FIRST) (LAST) (MIDDLE INT) ADDRESS: \_ MALE \_\_\_\_\_ FEMALE \_\_ **RELATIONSHIP TO PATIENT:** (STATE) (ZIP CODE) (CITY) \_\_\_ SPOUSE \_\_\_ PARENT/GUARDIAN \_\_\_ OTHER EMPLOYER: \_\_ SS#: **EMPLOYER** ADDRESS: HOME PHONE: WORK PHONE: \_\_\_\_\_\_ EXT: \_\_\_\_\_

## CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

(ZIP CODE)

(STATE)

Case Manager/Adjuster\_

(CITY)

W/C Claim #

I hereby authorize the physician at Chicago Health Medical Group, the nurses, and staff, under their direction, to conduct such examinations, administer treatment and medications, as they deem necessary or advisable. I hereby authorize the release of any information acquired by this facility during the course of my examination and/or treatment to my employer, prospective employer, and/or insurance carrier as required.

DATE SIGNATURE OF PATIENT/GUARDIAN