Welcome Please complete this form completely in ink. This information will remain confidential.

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Mendez | First name: Ana | | | Initial: A. | Date of birth: 03/24/1990 | Home phone: 312-555-3606 | | | |
| **Address:**  3457 W. 63d Place | | | | | **Marital Status: (check appropriate box)**  **S M** ⌧ **D W** | | | Sex **M** ⌧ **F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60629-4270 | | **Social Security Number:**  295-99-3325 | | | | |
| **Patient’s employer: (If student, name of school.)**  Lisle School District #12 | | | | | **Employment address:**  12224 Valley Road  Lisle, 60532  **Business phone:** 312-555-8852 | | | | |
| **Bill to:**  self | | | | | **Relationship:**  ---- | | | | |
| **Address:**  ---- | | | | | **City:**  ---- | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Maria Mendez | | | | | **Relationship:**  Sister | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-3606 work: 312-555-6456 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Blue Cross and Blue Shield | | | | | **Secondary insurance company:**  ----- | | | | |
| **Policyholder’s name: DOB:**  Ana Mendez 03/24/1990 | | | | | **Policyholder’s name: DOB:** | | | | |
| **Policy #: Group #:**  295-99-3325 354 | | | | | **Policy #: Group #:** | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  severe cold | | | | | **Name of referring physician:**  ------------ | | | | |
| Ana Mendez Patient’s signature/Parent or guardian’s signature | | | | | 03/15/20--  **Today’s date** | | | | |

###### WP