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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Morton | First name: Sarah | | | Initial: M. | Date of birth: 01/27/2000 | Home phone: 312-555-2324 | | | |
| **Address:**  723 W. Sixth Place | | | | | **Marital Status: (check appropriate box)**  ⌧ **S M D W** | | | Sex **M** ⌧ **F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60621-2314 | | **Social Security Number:**  899-34-2834 | | | | |
| **Patient’s employer: (If student, name of school.)**  Universal Photo, Inc. (mother) | | | | | **Employment address:**  2204 S. Springfield Avenue  Chicago, IL 60625-2701  **Business phone:** 312-555-8876 | | | | |
| **Bill to:**  Esther Morton | | | | | **Relationship:**  Mother | | | | |
| **Address:**  same | | | | | **City:**  Same | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Esther Morton | | | | | **Relationship:**  Mother | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-2324 work: 312-555-8876 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Northstar Insurance | | | | | **Secondary insurance company:**  ----- | | | | |
| **Policyholder’s name: DOB:**  Esther Morton 10/12/1968 | | | | | **Policyholder’s name: DOB:** | | | | |
| **Policy #: Group #:**  300-29-1874 255-03 | | | | | **Policy #: Group #:** | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  losing weight | | | | | **Name of referring physician:**  ------------ | | | | |
| Esther Morton Patient’s signature/Parent or guardian’s signature | | | | | 05/08/20--  **Today’s date** | | | | |

###### WP