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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Phan | First name: Marc | | | Initial: W. | Date of birth: 10/23/2019 | Home phone: 312-555-3344 | | | |
| **Address:**  9340 S. Green Street | | | | | **Marital Status: (check appropriate box)**  ⌧ **S**  **M**  **D**  **W** | | | Sex ⌧ **M**  **F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60620-8129 | | **Social Security Number:**  888-99-9228 | | | | |
| **Patient’s employer: (If student, name of school.)**  University Hospital (father) | | | | | **Employment address:**  5500 N. Ridgeway Avenue  Chicago, IL 60625-1200  **Business phone:** 312-555-2577 | | | | |
| **Bill to:**  Tam Phan | | | | | **Relationship:**  Father | | | | |
| **Address:**  same | | | | | **City:** | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Tam Phan | | | | | **Relationship:**  Father | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-3344 work: 312-555-2577 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  University Health Plan | | | | | **Secondary insurance company:**  ------------- | | | | |
| **Policyholder’s name: DOB:**  Tam Phan 02/14/1994 | | | | | **Policyholder’s name: DOB:**  ------------ | | | | |
| **Policy #: Group #:**  888-90-8229 A287-05 | | | | | **Policy #: Group #:**  ----------- | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  Earache | | | | | **Name of referring physician:**  ------------ | | | | |
| Tam Phan Patient’s signature/Parent or guardian’s signature | | | | | 04/19/20--  **Today’s date** | | | | |

###### WP