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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Sun | First name: Cheng | | | Initial: | Date of birth: 08/11/1970 | Home phone: 312-555-3750 | | | |
| **Address:**  2235 W. School Street | | | | | **Marital Status: (check appropriate box)**  **S** ⌧ **M D W** | | | Sex ⌧ **M F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60618-5785 | | **Social Security Number:**  285-90-2125 | | | | |
| **Patient’s employer: (If student, name of school.)**  Billings, Inc. | | | | | **Employment address:**  7580 W. 65th Street  Chicago, IL 60638-5680  **Business phone:** 312-555-8149 | | | | |
| **Bill to:**  self | | | | | **Relationship:**  --- | | | | |
| **Address:**  same | | | | | **City:** | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Mai Tuo Sun | | | | | **Relationship:**  Wife | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-3750 work: 312-555-8809 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Metro State Plan | | | | | **Secondary insurance company:**  ------------- | | | | |
| **Policyholder’s name: DOB:**  Cheng Sun 08/11/1970 | | | | | **Policyholder’s name: DOB:**  ------------ | | | | |
| **Policy #: Group #:**  285-90-2125 35A | | | | | **Policy #: Group #:**  ----------- | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  foreign body in eye | | | | | **Name of referring physician:**  ------------ | | | | |
| Cheng Sun Patient’s signature/Parent or guardian’s signature | | | | | 11/08/20--  **Today’s date** | | | | |

###### WP