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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Lund | First name: Laura | | | Initial: L. | Date of birth: 01/04/2006 | Home phone: 312-555-4100 | | | |
| **Address:**  13419 S. Buffalo Avenue | | | | | **Marital Status: (check appropriate box)**  ⌧ **S**  **M**  **D**  **W** | | | Sex  **M** ⌧ **F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60633-2010 | | **Social Security Number:**  899-90-0072 | | | | |
| **Patient’s employer: (If student, name of school.)**  St. Anne’s High School  North Auto Parts (father) | | | | | **Employment address:**  4550 N. Mason Avenue  Chicago, IL 60632-1185  **Business phone:** 312-555-8840 | | | | |
| **Bill to:**  Lawrence Lund | | | | | **Relationship:**  Father | | | | |
| **Address:**  same | | | | | **City:** | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Lawrence or Amy Lund | | | | | **Relationship:**  Parents | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-4100 work: 312-555-9143 mother | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Employee Benefit | | | | | **Secondary insurance company:**  ------------- | | | | |
| **Policyholder’s name: DOB:**  Lawrence Lund 03/29/1976 | | | | | **Policyholder’s name: DOB:**  ------------ | | | | |
| **Policy #: Group #:**  200-66-3986-01 733R | | | | | **Policy #: Group #:**  ----------- | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  soccer athletic physical | | | | | **Name of referring physician:**  ------------ | | | | |
| Amy Lund Patient’s signature/Parent or guardian’s signature | | | | | 04/18/20--  **Today’s date** | | | | |

###### WP