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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Matthews | First name: Ardis | | | Initial: L. | Date of birth: 09/10/1987 | Home phone: 312-555-3178 | | | |
| **Address:**  4443 W. Monroe Street | | | | | **Marital Status: (check appropriate box)**  **S** ⌧ **M D W** | | | Sex **M** ⌧ **F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60624-8966 | | **Social Security Number:**  340-99-6546 | | | | |
| **Patient’s employer: (If student, name of school.)**  Arling Electronics (husband) | | | | | **Employment address:**  4492 W. Foster Avenue  Chicago, IL 60625-2397  **Business phone:** 312-555-8848 | | | | |
| **Bill to:**  Earl Matthews | | | | | **Relationship:**  Husband | | | | |
| **Address:**  same | | | | | **City:** | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Earl Matthews | | | | | **Relationship:**  Husband | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-3178 work: 312-555-8848 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Arling Employee Plan | | | | | **Secondary insurance company:**  ------------- | | | | |
| **Policyholder’s name: DOB:**  Earl Matthews 08/05/1985 | | | | | **Policyholder’s name: DOB:**  ------------ | | | | |
| **Policy #: Group #:**  294-82-8099-02 33A | | | | | **Policy #: Group #:**  ----------- | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  Dizziness | | | | | **Name of referring physician:**  ------------ | | | | |
| Ardis Matthews Patient’s signature/Parent or guardian’s signature | | | | | 01/21/20--  **Today’s date** | | | | |

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