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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Sinclair | First name: Gene | | | Initial: E. | Date of birth: 11/19/1942 | Home phone: 312-555-4381 | | | |
| **Address:**  2721 W. 18th Street | | | | | **Marital Status: (check appropriate box)**  **S** ⌧ **M D W** | | | Sex ⌧ **M F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60608-6260 | | **Social Security Number:**  322-91-7722 | | | | |
| **Patient’s employer: (If student, name of school.)**  retired | | | | | **Employment address:**    **Business phone:** | | | | |
| **Bill to:**  self | | | | | **Relationship:**  ---- | | | | |
| **Address:**  ---- | | | | | **City:**  ---- | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Elizabeth Sinclair | | | | | **Relationship:**  Wife | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-4381 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  -- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Medicare | | | | | **Secondary insurance company:**  Blue Cross | | | | |
| **Policyholder’s name: DOB:**  Gene Sinclair 11/19/1942 | | | | | **Policyholder’s name: DOB:**  Gene Sinclair 11/19/1942 | | | | |
| **Policy #: Group #:**  322-91-7722A | | | | | **Policy #: Group #:**  322-91-7722 | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  bursitis, shoulders | | | | | **Name of referring physician:**  ------------ | | | | |
| **Gene Sinclair** Patient’s signature/Parent or guardian’s signature | | | | | 10/11/20--  **Today’s date** | | | | |

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