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

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Rogers | First name: Clarence | | | Initial: P. | Date of birth: 09/25/1986 | Home phone: 312-555-5297 | | | |
| **Address:**  4713 W. 82d Place | | | | | **Marital Status: (check appropriate box)**  **S** ⌧ **M D W** | | | Sex ⌧ **M F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60652-2111 | | **Social Security Number:**  463-71-3030 | | | | |
| **Patient’s employer: (If student, name of school.)**  Websters’ Restaurant | | | | | **Employment address:**  4300 W. Grace Street  Chicago, IL 60641-9258  **Business phone:** 312-555-8852 | | | | |
| **Bill to:**  self | | | | | **Relationship:**  --- | | | | |
| **Address:**  ---- | | | | | **City:** | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Lisa Rogers | | | | | **Relationship:**  Wife | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-5297 work: 312-555-8322 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Metro State Plan | | | | | **Secondary insurance company:**  University Health Plan | | | | |
| **Policyholder’s name: DOB:**  Clarence Rogers 09/25/1986 | | | | | **Policyholder’s name: DOB:**  Lisa Rogers 05/29/19-- | | | | |
| **Policy #: Group #:**  463-71-3030 55A | | | | | **Policy #: Group #:**  465-77-3821-01 77C | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  Rash | | | | | **Name of referring physician:**  ------------ | | | | |
| Clarence Rogers Patient’s signature/Parent or guardian’s signature | | | | | 07/05/20--  **Today’s date** | | | | |

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