S&K Medical Center

1S376 Summit Ave
Court C, Unit 4B
Oakbrook Terrace, IL 60181

Patient Registration Form

PATIENT INFORMATION

Last Name: __________________________ First Name: ___________________________ Initial: ________

Date of Birth: _____/_____/________ Social Security Number: _____-_____-________ Sex: M F

Marital Status: Married Single Divorced Widowed

Home Address: ____

Apt/Unit: _________________ City: ______________________________ State: ______ Zip Code: _______

Cell Phone: _________________________________ Home Phone: _________________________________

Work Phone: _______________________________ E-Mail Address: _______________________________

BACKGROUND INFORMATION

Due to recent legislation, medical facilities are required to gather the following information:

Please Circle All that Apply:

Asian White/Caucasian

Black or African American Hispanic/Latino

Other (please specify): ____________________________

EMERGENCY CONTACT INFORMATION

Name: _______________________________________ Relationship to Patient: _______________________

Cell Phone: __________________________________ Home/Work Phone: __________________________

CANCELLATION POLICY: If you need to cancel or reschedule your appointment, please notify our office at least 24 Hours in advance by calling (630) 953-9009. Failure to do so may result in a cancellation fee.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of Medical Benefits, if any, otherwise payable to me for his services as described, realizing that I am responsible to pay non-covered services. I also realize that I am responsible for any other costs incurred while collecting my outstanding balance(s). In addition, I authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_______________________________ _____________________

Signature of Patient or Legal Guardian **Date**