Michael F. Scheer, M.D., F.A.C.S. Daniel A. Liesen, M.D., F.A.C.S. Amit Parikh, D.O., F.A.C.O.S.

*Thank you for selecting our healthcare Team! We will strive to provide you with the best possible care.*
*To help us meet all your healthcare needs, please fill out this form completely.*
*Your Driver's License and Social Security number is required in order to determine identity. It is the policy of our practice to implement an Identity Theft Prevention Program to detect, prevent and mitigate identity theft in connection with new and existing patient accounts.*

***Drivers License #*** _____

## *Patient Information* *(CONFIDENTIAL)*

***Soc. Security #*** _____

*Last Name* _____ *First Name* _____ *MI* _____
*Address* _____ *City* _____ *State* _____ *Zip Code* _____
*Date of Birth* _____ *Sex* _____ ***Phone#*** _____ *Marital Status* _____
*Race:* _____ *Language Preference:* _____
*Pharmacy Preference and Location:* _____
*Occupation* _____ ***Cell Phone #*** _____ *Email:* _____
*Patient's Employer* _____ *Work #* _____
*Work Address* _____ *City, State, Zip* _____
*Spouse or Parent's Name* _____ *Employer* _____ *Work #* _____
*Whom May We Thank for Referring You?* _____
***Person to Contact in Case of Emergency:***
_____ *Phone #* _____ *Relationship:* _____

***Name of Family Physician*** _____

## *Insured Information*

*Relationship to*
*Name of insured* _____ *Patient* _____
*Address* _____ *Phone#* _____
*City* _____ *State* _____ *Zip Code* _____
*Birthdate* _____ *Soc. Sec. #* _____ *Work #* _____
*Employer* _____

## *Primary Insurance*

*HMO* ____ *PPO* _____ *POS* _____ *Workman's Comp* ____ ***Co-pay amt.$*** _____
*Insurance Company* _____ *Group #* _____
*Policy / I.D. #* _____ *Phone #* _____
*Address* _____ *City* _____ *State* _____ *Zip* _____
***If Workers Compensation***: *Date of Injury* _____ *Contact Person:* _____
*Phone #* _____

**DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO If yes, complete the following**
*Name of Insured* _____ *Relationship to Patient* _____
*Birthdate* _____ *Soc. Sec. #* _____ *Employer* _____
*Insurance Company* _____ *Group #* _____
*Policy / I.D. #* _____ *Phone #* _____
*Address* _____ *City* _____ *State* _____ *Zip* _____

***Financial Arrangements:*** *For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected at the time of service unless other arrangements have been made with our office.*
_____ ***Cash*** _____ ***Personal Check*** _____ ***Visa*** _____ ***MasterCard***

## *Authorization and Release*

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize you to release and to receive any medical information to those you deem necessary. I hereby authorize my insurance company to pay directly to Surgeons of Northern Illinois benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____/_____
Signature of patient or parent if minor Date