

DUPAGE OPHTHALMOLOGY REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION

Date Home () Cell Phone ()
Name Last Name First Name Middle Initial SS#
Address Email
City State Zip Code
Sex Male Female Age Birthdate Married Separated Partnered for yrs
Minor Single Widowed
Patient Employer/School Occupation
Employer/School Address Employer Phone ()
City State Zip Code
In case of Emergency who should be notified?
Phone () Relationship
Referred by: Primary Care Physician:

PRIMARY INSURANCE

Person Responsible for Account Last Name First Name Middle Initial
Relation to Patient Birthdate SS#
Address (if different from Patient's) Phone ()
City State Zip Code
Person Responsible Employed by Occupation
Business Address Business Phone ()
Insurance Company Insurance Phone ()
Group # Subscriber # Copay

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name Birthdate Relation to Patient
Address (if different from Patient's) Phone ()
City State Zip Code
Person Responsible Employed by Occupation
Business Address Business Phone ()
Insurance Company Insurance Phone ()
Group # Subscriber # Copay

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to DuPage Ophthalmology, SC; Balaji Gupta, MD; John Hahn MD; Nataalka Manastersky OD; Sheridan Lam, MD; and/or Sujaya Rupani, MD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the use of my health care information and such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. This consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.

Signature of Patient, Parent or Guardian or Personal Representative Date
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient