DUPAGE OPHTHALMOLOGY

Balaji Gupta M.D. | Sheridan Lam M.D.

Patient Registration Form

Today's Date: **Acct. #**

PATIENT INFORMATION

Name: **Date of Birth:**

Address:

City: **State:** **Zip:** **Gender:**

Home Phone: **Cell Phone:**

Email:

Preferred Method of Contact ☐ **Phone Call** ☐**Text Message** ☐**E-mail**

Emergency Contact: **Phone:**

Responsible Party: (if patient is a minor):

Who referred you to our practice?:

Who is your primary care physician?:

Phone #: **Fax #:**

Marital Status:

Do you consider yourself Hispanic or Latino?:

Preferred Language: **Race:**

Pharmacy Information:

INSURANCE INFORMATION

Primary Insurance Company:

Policy Holder: **Date of Birth:**

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Insurance ID: **Group Number:**

Secondary Insurance Company:

Policy Holder: **Date of Birth**:

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Insurance ID: **Group Number:**

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to DuPage Ophthalmology, SC; Balaji Gupta, MD; Sheridan Lam 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 heath 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 of the benefit payable for related services. The consent will end upon termination of coverage with above-named Insurance Company(ies) or one year from the date signed below

Signature of Patient, Parent, Guardian, or Personal Representative *Date*

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