The Medical Group of Kankakee County
Patient Information Sheet

Last Name | First Name | Middle Name

Date of Birth | Gender | Race | Social Security Number | Marital Status

(Area Code)Home Phone | (Area code) Work Phone | (Area Code) Cellular phone

Home Address | City | State | Zip Code

Confidential Email Address | Employment Status FT/PT | Occupation

Employer | Employer address

Primary Care Physician | How did you hear about our practice?

Guarantor Information (Person Responsible for Bill)

Last Name | First Name | Middle Name

Relationship to Patient | Guarantor's Date of Birth | Social Security Number

(Area Code)Home Phone | (Area code) Work Phone | (Area Code) Cellular phone

Home Address | City | State | Zip Code

Emergency Contact

Name | Relationship | (Area code) Phone Number

Signature of Patient or Guardian | Date

Primary Insurance Information

Insurance Company Name ______ Insurance Co. Phone Number ______ Employer ______

Claim's Address ______ City ______ State ______ Zip Code ______

ID# ______ Group# ______

Policy Holder's Name ______ Social Security Number ______ Date of Birth ______ Telephone number ______

Address of Policyholder ______ Relation to Patient ______

Secondary Insurance Information

Insurance Company Name ______ Insurance Co. Phone Number ______ Employer ______

Claim's Address ______ City ______ State ______ Zip Code ______

ID# ______ Group# ______ Employer ______

Policy Holder's Name ______ Social Security Number ______ Date of Birth ______ Relation to Patient ______

Please present insurance card to the receptionist so a copy can be made for your file.

Payment of Benefits

I direct payment to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charge for those services.

Signature of Insured ______ Date ______

Release of Information

I hereby authorize The Medical Group of Kankakee County to release any information acquired in the course of my examination or treatment to my insurance company or other health care providers.

Signature of Insured ______ Date ______

01/09 Form Staff initials_______