Integrative Family Health Associates

Patient Demographic Information

Patient Name: _____ Birthdate: _____

Address: _____ Telephone # (H) _____

City, State, ZIP Code: _____ (W) _____

Email: _____ (C) _____

Social Security Number: _____ Which number may we call to confirm your appointments? _____

Occupation: _____ May we leave a detailed message? Yes No

Employer: _____ If so, with whom? Voicemail Self Spouse Other _____

Address: _____ Emergency Contact: _____

Employer Phone Number: _____ Relationship to Patient: _____

Marital Status: S M S/D W Contact Phone Number: _____

Race*: _____ Ethnicity*: _____

Language Preferred*: _____

Payment Method: Type of Insurance: _____ Self Pay: _____

Whose Insurance: Self spouse parent Their birthdate: _____

Who may we thank for referring you to us? _____

***** Cultural lifestyle patterns (e.g., food choices and smoking habits) and beliefs about the use of health care influence the quality of care received regardless of the person's country of origin, language, immigration status, or socioeconomic status (SES). The importance of knowing a patient's race, ethnicity, and language need is not limited to understanding the issues facing recent immigrants' health access or outcomes; race, ethnicity, and language data can reveal risks for health care disparities in native-born as well as foreign-born populations.

Phone: (708) 482-1099
Fax: (708) 482-0335
4727 Willow Springs Road
Suite 3S
La Grange, IL 60525

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Patient Insurance Information

Patient Name: _____

Do you have insurance? ☐ Yes ☐ No

If "No", who is the responsible party? _____

Insurance Company Name: _____

Coverage Type: ☐ Primary ☐ Secondary

Insurance Group Name:
(if applicable) _____

Insurance Subscriber ID Number: _____

Relationship of Patient to Insurance Subscriber (self, child, spouse, etc.): _____

(if different than patient)

Insurance Subscriber Name: _____

Insurance Subscriber Date of Birth: _____

Insurance Subscriber Phone Number: _____

Insurance Subscriber Email: _____

Insurance Subscriber Employer Name: _____

Insurance Subscriber Address: _____

_____

_____

Insurance Subscriber Phone Number: _____

Insurance Copay Amount: _____

Student Status of Patient: ☐ Full Time ☐ Part Time ☐ N/A

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