



Integrative Family Health Associates

Patient Demographic Information

Full Name: _____

Address: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Email: _____

Date of Birth: _____

Marital Status: _____

Payment Class: **Commercial Insurance**

Self Pay

Provider: **Dr. Feldman**
(choose one initially)

Dr. Davakos

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Phone: (708) 482-1099
Fax: (708) 482-0335

*4727 Willow Springs Road
Suite 3S
La Grange, IL 60525*



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