



## 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



## 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