Highland Park OB-GYN Associates, Ltd.
60 Revere Drive, Suite 750, Northbrook, IL 60062
847 272 7777 (Phone) **847 272 7709 (Fax)**

__Please provide any and all applicable insurance card(s) and picture ID to the receptionist__

Date _____ **__Patient Registration__**

Last Name: _____ **__Preferred Method of Communication: (Please Circle)__**

First Name: _____ Home Phone: _____ 1st 2nd 3rd 4th

Sex: Male ___ Female ____ Cell Phone: _____ 1st 2nd 3rd 4th

Address: _____ Work Phone: _____ 1st 2nd 3rd 4th

City/State: _____ Email Address: _____ 1st 2nd 3rd 4th

Employment Status: FT__ PT __ Retired __ Student __ Date of Birth: _____

Martial Status: Single __ Married __ Other: _____ Social Security #: _____

Other __ N/A __

Employer: _____ Primary Care Physician: _____

Employer Address: _____ Referring Physician: _____

City/State/Zip: _____

__Ethnicity (Check One__)

Non-Hispanic ___
Hispanic ___
Refused to Report ___

__Primary Race (Please Check One)__

Other Pacific Islander ___ Asian ___
Native American ___ White ___
Other Race ___ Hispanic ___
African American/Black ___ Native Hawaiian ___
Unreported/Refuse ___

Preferred Language: English ___ Spanish ___ Other _____ Interpreter Needed: Yes ___ No ___

Do you have an Advanced Directive such as a Living Will or Medical Power of Attorney? Yes ___ No ___

Is your visit with us today due to an automobile accident or work place accident? Yes ___ No ___

__Responsible Party Information__

Name: _____ Relationship: _____ DOB: _____

Address: _____ Employer: _____

City/State/Zip: _____ Address: _____

Work/Day Phone: _____ Social Security #:_____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone: _____

City/State/Zip: _____ Zip: _____

Do we have permission to contact this person regarding matters concerning your care? Yes __ No ___

Insurance Information

Primary Carrier Name:_____ City/State: _____

Insured's Name: _____ Relationship: _____

DOB: _____ Social Security #: _____

2nd Carrier Name: _____ City/State: _____

Insured's Name:_____ Relationship: _____

DOB: _____ Social Security #: _____

Pharmacy Information

Preferred Pharmacy Name: _____ Mail Order? Yes ___ No ___

Pharmacy Address: _____

Pharmacy Phone Number: _____

Electronic Prescriptions *Our electronic medical program accesses your prescriptions / medication history in order for us to safely prescribe your medication. By signing this you authorize us to do so.*

Authorization to Leave Message: I hereby authorize Highland Park OB-GYN Associate, LTD. to leave message by preferred method of communication? Yes ___ No ____

Authorization to pay benefits to physician: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____

Print Name Patient /Guardian

_____ _____

Signature **Date**

Authorization to release information: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

Print Name Patient /Guardian

_____ _____

Signature **Date**