CHICAGO HEALTH MEDICAL GROUP
PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____ **MALE** ___ **FEMALE** ___
(FIRST) (LAST) (MIDDLE INT)

ADDRESS: _____

MARITAL STATUS: ___ **SINGLE**
___ **MARRIED**
___ **OTHER (WIDOW, DIVORCE, SEPARTED)**

_____
CITY) (STATE) (ZIP CODE)

RACE: (check one)
__American Indian/Alaska Native __Middle Eastern/North African
__Asian/Oriental __White
__Black/African American __Other _____

SS#: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____ **EXT:** _____

ETHNICITY: (check one)
__Central American __Mexican
__Cuban __Not Hispanic or Latino
__Dominican __Puerto Rican
__Hispanic/Latino/Spanish __South American
__Latin American __Spaniard
__Other _____

CONTACT PREFERENCE:
___**Home Phone** ___**Cell/Mobile** ___**Work Phone** ___**Mail**

EMAIL: _____

PRIMARY CARE PHYSICIAN: _____

IS INJURY RELATED TO: (check one)
WORK _____ **AUTO ACCIDENT** _____ **OTHER** _____

EMPLOYER: _____

DATE OF INJURY: _____

EMPLOYER ADDRESS: _____

LAST DAY WORKED: _____

_____
(CITY) (STATE) (ZIP CODE)

SPOUSE'S NAME: _____**SPOUSE WORK PHONE:** _____ **EXT:** _____

EMERGENCY CONTACT: _____**(Relationship):**_____ _____
(NAME) *(PHONE - DIFFERENT FROM ABOVE)*

DO YOU HAVE AN ADVANCE DIRECTIVE? (LIVING WILL/POWER OF ATTORNEY) yes___ no___ If yes, please provide for our records.
ADVANCE DIRECTIVE INFORMATION PROVIDED _____ **PATIENTS RIGHTS AND RESPONSIBILITIES PROVIDED** _____
OFFICE STAFF INITIALS *OFFICE STAFF INITIALS*

POLICY HOLDER INFORMATION (Please complete, if different from patient information)

POLICY HOLDER NAME
OR WORKMAN'S COMP: _____ **DATE OF BIRTH:** _____ **AGE:** _____
(FIRST) (LAST) (MIDDLE INT)

ADDRESS: _____ **MALE** _____ **FEMALE** _____

_____
(CITY) (STATE) (ZIP CODE)

RELATIONSHIP TO PATIENT:
___ **SPOUSE** ___ **PARENT/GUARDIAN** ___ **OTHER**

EMPLOYER: _____ **SS#:** _____

EMPLOYER
ADDRESS: _____ **HOME PHONE:** _____

_____ **WORK PHONE:** _____ **EXT:** _____
(CITY) (STATE) (ZIP CODE)

W/C Claim #_____ **Case Manager/Adjuster**_____ **Phone**_____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician at Chicago Health Medical Group, the nurses, and staff, under their direction, to conduct such examinations, administer treatment and medications, as they deem necessary or advisable. I hereby authorize the release of any information acquired by this facility during the course of my examination and/or treatment to my employer, prospective employer, and/or insurance carrier as required.

_____ _____
DATE *SIGNATURE OF PATIENT/GUARDIAN*