Southwest Infectious Disease & Internal Medicine, S.C.
7804 W. College Dr., Palos Heights, IL 60463
Telephone: (708) 361-5778

REGISTRATION (Please Print)

Home # _____

Date: _____ Cell Phone #_____

Patient: _____

Last Name First Name Middle Initial

Street Address:_____

City: _____ State: _____ Zip: _____

Your Referring Dr. / Primary Care Dr. _____

Sex:❑M ❑F Age: ____ Birth Date: _____ ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Who is Responsible for this account? _____ Relationship to Patient: _____

Birth Date: _____

Business Name & Address: _____

Occupation: _____ Business Phone: _____

Do you have Medical Insurance? ❑ Yes ❑ No ➔ ❑ Medicare ❑ Medicaid ❑ Other

Name of Primary Insurer: _____ Group Number: _____

Name of Secondary Insurer: _____ Group Number: _____

* A copy of your card will be made for the billing record

In case of an emergency, who should be notified? _____Phone: _____

ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage with _____, and I assign directly to Southwest Infectious Disease
Name of insurance company
and Internal Medicine, S.C., (SWID&IM), all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize SWID&IM to release all information necessary to secure the payment of benefits and for the purpose of carrying out treatment or health care operations. I authorize the use of the signature on all the insurance submissions.

_____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Southwest Infectious Disease and Internal Medicine, S.C., for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCF A-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date