PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last)_____ (First) _____ (M.I.)_____DOB_____

Address _____ (City) _____ State_____ Zip_____

(M/F)_____ SS #_____Matital Status_____Cell Phone:_____

Home Phone:_____Email:_____How Did You hear about us?_____

EMERGENCY CONTACT _____ Phone #_____

REPONSIBLE PARTY (INSURED)

Guarantor's Name _____Guarantor's DOB_____(M/F)_____

Address _____Relation to Guarantor _____

Guarantor's Last 4 SS # _____Guarantor's Email_____Guarantor Phone#_____

PRIMARY INSURANCE

Name of Insurance Company _____Policyholder _____

(M/F)_____Policy Holder DOB_____Relation to Policyholder _____Insurance Group #_____

Insurance ID # _____ PolicyHolder Email_____

SECONDARY INSURANCE

Name of Insurance Company _____Policyholder _____

(M/F)_____Policy Holder DOB_____Relation to Policyholder _____Insurance Group #_____

Insurance ID # _____ PolicyHolder Email_____

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments. The performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I hereby authorize **DR BRENDAN LEE PC** to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to **DR BRENDAN LEE PC**, of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization.
A photocopy of this authorization shall be considered as valid as the original. Further, I acknowledge that I am indebted for past due charges and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay all collection and court costs including attorney fees.

In accordance with the provisions of the code (law) of Illinois (whenever any health care provider or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may according to the current guidelines for the Centers for Disease Control, transmit human immunodeficiency virus). The patient whose body fluids were involved in the exposure shall be deemed to have consented for testing for infection with human immunodeficiency virus. If there is an exposure and the patient's test is positive the attending physician will notify the patient, any person exposed, and the Illinois Department of Public Health and appropriate counseling will be offered. I have reviewed and understand my **PATIENT RIGHTS AND RESPONSIBILITES**. I certify that I have read and fully understand the above statements and consent fully to its contents.

Patient/Guarantor Signature _____ **Date**_____

DR BRENDAN LEE PC