Chicago Family Asthma & Allergy, S.C.
Aaron Donnell, M.D. and Kelly Newhall, M.D.

Patient Registration

Date: _______________

Patient Name: ____ Date of Birth: _____________________

Address: ____ State _________Zip____________

Phone: Home: ________________________ Work: ________________________ Mobile: ___________________________
OK to Leave Message at Home: ( ) Yes ( ) No; Work: ( ) Yes ( ) No; Mobile: ( ) Yes ( ) No; Preferred: _____________

Sex: ____ Marital status: ___________ Social Security #: ________________ Occupation: __________________________

E-mail address (optional): _____________________________________ Email user, if not the patient: _________________

Responsible party: __________________________________ Relationship to patient: _____________ DOB: _____________

Responsible party Phone #, Address (if different): ____

Emergency contact, relationship to patient: _____________________________________ Phone #:____________________

Pharmacy name, address, phone number: ____

Referred by (address and phone if doctor): ____

Primary care doctor (address, phone): ____

Primary Insurance

Company: _________________________________ ID/Policy #: _________________________ Group #:_________________

Subscriber name: ____________________________________ DOB: _____________ SSN: ___________________________

Subscriber address: ____

Phone #: _____________________ Co-pay: __________Employer name: ____

Secondary Insurance

Company: _________________________________ ID/Policy #: _____________________ Group #:____________________

Subscriber name: ____________________________________ DOB: _____________ SSN: ___________________________

Subscriber address: ____

Phone #: _____________________ Co-pay: __________Employer name: ____

Authorization for Medical Care, Payment, and Release of Information

I, the undersigned, hereby authorize the physicians of Chicago Family Asthma & Allergy, S.C. to render medical evaluation and treatment for the named patient. I authorize payment of medical benefits for any services furnished to me or to the patient by Chicago Family Asthma & Allergy, S.C. I understand that I am financially responsible for any amount not covered by my contract. I Authorize Chicago Family Asthma & Allergy, S.C. to release any information acquired in the course of my evaluation or treatment to any provider, other party, or my insurance company or their agent for the purpose of treatment, payment, or practice operations.

__________________________________ ____ __________________

Patient Signature — Parent or Guardian Signature if patient<18 years old — Date