Chicago Family Asthma & Allergy, S.C.

2551 N Clark St, Ste 100, Chicago, IL 60614
Phone: (773) 388-2322 Fax : (773) 388-2333 www.chicagofamilyasthma.com

Date: _____ Patient Registration

Patient Name: _____ Date of Birth:_____

Current Gender Identity: _____ Sex Assigned at Birth: _____ Preferred pronouns: _____

Address: _____City_____ State _____Zip_____

Phone(s): Mobile: _____ Home: _____ Work: _____

E-mail address: _____ Check if OK to leave voice mail details on mobile phone ❑

Appointment reminders preference (check one or both): ❑ Text Message ❑ Voice

❑ Please send e-mail invitation to online Patient Portal for labs or messaging (or Healow medical care app)

Responsible Party: _____ Relationship to Patient: _____ DOB: _____

Emergency Contact/ Relationship to Patient: _____Phone #:_____

Pharmacy (**NAME, ADDRESS, PHONE #**): _____

Primary Care Physician (**NAME, ADDRESS OR PHONE #**): _____

Referred by/heard about us: _____

Primary Insurance

Company: _____ ID/Policy #: _____ Group #:_____

*Subscriber name: _____ Subscriber Address: _____

DOB: _____ Phone #: _____ Co-pay: _____

Secondary Insurance (if applicable)

Company: _____ ID/Policy #: _____ Group #:_____

Subscriber name: _____ Subscriber Address: _____

DOB: _____ Phone #: _____ Co-pay: _____

Authorization for Medical Care, Payment, and Release of Information:

I, the undersigned, hereby authorize the practitioners 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 Guardian Signature if patient<18 years old Date