Chicago Infertility Associates, Ltd.
Alexian Brothers Medical Center
Eberle Building 800 Biesterfield rd., suite 645
Elk Grove Village, IL 60007

Today's date: ________________

PATIENT INFORMATION

Patient's last name: ________________ First: __________ Middle: __ ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (Check one)

Birth date: ________________ Single❑ Mar❑ Div❑ Sep❑ Wid❑

Street address: ____________________________________ Social Security no.: ________________

P.O. box: ________________ City: ______________________________ State: __________ ZIP Code: ___________

Home phone no.: ________________ Work no.: ________________ Cell no.: ________________

Occupation: _______________ Employer: ____ Phone no.: ________________

Allergies: (Medication and Type of Reaction): ____

____

____

Partners Name: ____________________ Birthday: ________________ SS#: ___________________________

Home phone no.: ________________ Work no.: ________________ Phone no.: _______________________

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ______________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Pharmacy Name: ____ phone no.: ________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: ____________________ Birth date: __________ Address (if different): ______________________________________ Home phone no.: _________________________

Is this person a patient here? ❑ Yes ❑ No ______________________________________

Occupation: ____________ Employer: ____________ Employer address: ____ Employer phone no.: _________________________

Primary Insurance Information

Is this patient covered by insurance? ❑ Yes ❑ No Please indicate primary insurance___________________________

Subscriber's name: ________________ Subscriber's S.S. no.: __________________________ Birth date: _______________

Group no.: _______________ Group no.: _______________ Policy no.: ________________ Co-payment: $ ____________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Other

Secondary Insurance Information

Name of secondary insurance (if applicable): _______________________________ Subscriber's name: ____________________

Group no.: ______________________ Policy no.: ___________________________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): ______________________________ Relationship to patient: _______________ Home phone no.: _____________ Work phone no.: _____________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chicago infertility associates or insurance company to release any information required to process my claims.

Patient/Guardian signature: ____ *Date:* ____________