

**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