Advocate Medical Group

REGISTRATION FORM

Acct #:
Provider:

Patient Information

Social Security #	Full Name: Last	First	Middle	Maiden (Other)
Address: Street or Rural Route		City	State	Zip Code

Home Phone #	Work Phone #	Extension	Cell Phone #

Date of Birth	Age	Marital Status Single Married Widowed Divorced	Sex (circle one) Female Male	Spouse's Name

Reason for Visit	Patient's Primary Care Physician and Phone #

Patient Additional Information:	
Can messages be left on voicemail? Home: Y / N Work: Y / N Cell: Y / N	Emergency contact for patient:
Information can be released to the following person(s) (include date of birth)	Name: Phone: Relationship:
Patient's email address:	Living Will: Y / N Power of Attorney Y / N

PATIENT CURRENT EMPLOYMENT INFORMATION

Occupation	Employer	Employer Address

If Student Indicate School	If Patient is a Minor, provide Name of Parent(s)) or Legal Guardian (legal documentation required):

RESPONSIBLE PARTY ☐ Please check box if Responsible Party is the same as the Patient.

Social Security #	Full Name: Last	First	Middle	Maiden (Other)
Address: Street or Rural Route P.O. Box		City	State	Zip

Home Phone #	Work Phone #	Extension	Email Address

Date of Birth	Age	Sex (cirlce one) Female Male	Relationship to Patient

Responsible Party Employer	Responsible Party Employer Address

INSURANCE INFORMATION Please provide copy of your insurance card to front office respresentative.

Name of Primary Insurance Company		Name of Secondary Insurance Company	
Subscriber (Policyholder if not patient)	Date of Birth	Subscriber (Policyholder, if not patient)	Date of Birth
Subscriber Address, City, State, & Zip		Subscriber Address, City, State, & Zip	
Social Security #	Relationship to Patient	Social Security #	Relationship to Patient

Revised: 04/21/10 jmk

Is this visit due to an accident? Y N		**Date of Accident/On-set:**	
If yes, is the accident an (circle one) Auto Accident Work Injury Other **Explain other:**			
Employer Name		**Phone #** **( )**	
Mailing Address	**City**	**State**	**Zip**
Work Company Carrier Name			
Is this visit for a pre-employment exam? Y N		**If yes, please complete**	
Potential Employer Name		**Phone #** **( )**	
Mailing Address	**City**	**State**	**Zip**

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

X Signature of Patient, Parent or Legal Guardian Date

If patient is a minor:

My signature authorizes evaluation and treatment for my child and also authorizes consent to medical and surgical procedures and immunizations for the child named herein _____ (Name of Child).

Financial Responsibility / Medical Information Release

I hereby authorize payment of medical benefits directly to BroMenn Physicians Management Corporation, DBA BroMenn Medical Group and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim and/or for the purpose of determining eligibility of employment. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), Drug Screen and Breath Alcohol Testing. **I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies and/or employer. I agree that all amounts are due upon request and are payable to BroMenn Medical Group. I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of BroMenn Medical Group, if any.**

X Signature of Patient, Parent or Legal Guardian Date

FOR OFFICE USE ONLY:

Copy of insurance card obtained and scanned _____ *Initials*

Current insurance verified and already on file _____ *Initials*

Patient's demographics verified and updated _____ *Initials*

Photo ID verified for new patients and/or per practice specific policy _____ Initials

Advocate Medical Group

NOTICE OF PRIVACY PRACTICE

By signing this document, I acknowledge that a copy of the Advocate Medical Group Notice of Privacy Practices has been made available to me. I understand that I may request to receive a copy of the notice at any time.

_____

Please Print Patient's Name

_____

Signature of Patient or Legal Guardian if patient is a minor or unable to sign

_____

If someone other than the patient signed, please indicate relationship to patient

_____

Date of Signature

Advocate BroMenn Medical Center | ENT Surgical Associates of Central Illinois

207 N. Landmark, Suite A
Normal, IL 61761
Phone: 309-268-3200
Fax: 309-268-3213

Email & SMS Text Opt-in Agreement

First name _____ M.I. ____ Last name _____

Date of birth _____

Address _____

Home phone number _____

Cell phone number _____

Email address _____

Email Opt-in

Dear Patient – We will be implementing a follow-up and appointment reminder system that will send and email to you with information regarding your office visit. Studies show that more than 70% of patients say reminders help them remember an appointment. Check the box below to *Opt-in* and indicate that you would like to be included in this program. Your information is strictly to help us provide better quality care and is not shared with anybody else. You can *Opt-out* at any time.

☐ I would like to receive email correspondence for appointment follow-ups, reminders, or patient education information.

☐ I would NOT like to receive email correspondence for appointment follow-ups, reminders, or patient education information.

SMS Text Opt-in

We are considering implementing an appointment reminder system where an SMS text is sent to your mobile phone within 24 hours of your appointment. Studies show that more than 70% of patients say reminders help them remember an appointment. Check the box below to *Opt-in* and indicate that you would like to be included in this program. Your information is strictly for this purpose and not shared with anybody else. You can *Opt-out* at any time.

☐ I would like to receive appointment reminders by having an SMS text sent to my cell phone within 24 hours of my appointment.

☐ I would NOT like to receive appointment reminders by SMS text sent to my cell phone within 24 hours of my appointment.