REGISTRATION FORM

PATIENT — New Patient ____ or Annual Patient ___

Last Name First Name MI | Sex: M or F | Date of Birth / /

Address City State Zip Code

Phone # ( )
Marital Status: S M W D SEP

Are you an Altgeld Murray (Garden) Resident? Yes or No
Do you live in Public Housing? Yes or No

Cell Ph # ( ) E-Mail Address: Consent to call YES or NO Consent to Text Yes or No

Race: Asian____ Native Hawaiian_____ Pacific Islander____ Black/African____ American Indian/Alaska Native___ White___ Other_______

Ethnicity: Hispanic or Non-Hispanic Are you a Veteran? ___Yes ___ No Household Size________ Monthly Income

Emergency Contact: | Relationship to Patient: Phone # Allergies:

Employment Status | Employer Name | Work Phone # ( ) | Social Security Number

Employer Address City State Zip Code

Referred by Ph # of Referral ( )

Responsible Party (Complete this section if the person responsible for the bill is not the patient)

Last Name First Name MI | Sex F M | Date of Birth

Address City State Zip | Social Security Number

Relation to Patient
____Spouse ___Parent _____Other | Employer Name | Work Phone # ( )

Spouse or Parent (if minor): | Home Phone # ( )

Insurance (If you have multiple coverage, supply information from both carriers)

Primary	Secondary
Primary Carrier Name Date of Birth	Secondary Carrier Name Date of Birth
Name of the Insured (Name on ID Card)	Name of the Insured (Name on ID Card)
Patient's relationship to the insured _____Self _____Spouse _____Child	Patient's relationship to the insured __Self ___Spouse __ Child
Insured ID#	Insured ID#
Group # or Company Name	Group # or Company Name
Insurance Address	Insurance Address
Phone # ( ) Copay $	Phone # ( ) Copay $

Other Information

Is patient's condition related to: | Reason for visit:
______Employment ____ ___Auto Accident (if yes, state in which accident occurred: ________ ______Other Accident

Date of Accident: / / Date of First Symptom of Illness: / /

Financial Agreement and Authorization for Treatment

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I hereby authorize direct payment of surgical/medical benefits to TCA Health, Inc. for services rendered by the clinician/ provider in person or under his/her supervision. I understand. that I am financially responsible for any balance not covered by my insurance. I hereby authorize the release of any medical information necessary in order to process a claim for payment on my behalf.

Signature_______________________________________ Date: ______________________________