

MACNEAL HOSPITAL PHYSICIAN PRACTICES

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____
(FIRST) (LAST) (MIDDLE INT)

ADDRESS: _____ MALE _____ FEMALE _____

(CITY) (STATE) (ZIP CODE)

MARITAL STATUS: _____ SINGLE
_____ MARRIED
_____ OTHER (WIDOW, DIVORCE, SEPARATED)

SS#: _____ HOME PHONE: _____

PRIMARY CARE PHYSICIAN: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____ EXT: _____

EMPLOYER ADDRESS: _____ CONTACT PREFERENCE: _____ HOME PHONE _____ CELL/MOBILE
_____ WORK PHONE _____ MAIL

(CITY) (STATE) (ZIP CODE)

IS INJURY RELATED TO: (check one)
WORK _____ AUTO ACCIDENT _____ OTHER _____

SPOUSE'S NAME: _____ DATE OF INJURY: _____

SPOUSE WORK PHONE: _____ EXT: _____ LAST DAY WORKED: _____

EMERGENCY CONTACT: _____ (Relationship): _____
(NAME) (PHONE - DIFFERENT FROM ABOVE)

DO YOU HAVE AN ADVANCE DIRECTIVE? (LIVING WILL/POWER OF ATTORNEY) yes___ no___ If yes, please provide for our records.
ADVANCE DIRECTIVE INFORMATION PROVIDED _____ PATIENTS RIGHTS AND RESPONSIBILITIES PROVIDED _____
OFFICE STAFF INITIALS OFFICE STAFF INITIALS

POLICY HOLDER INFORMATION (Please complete, if different from patient information)

POLICY HOLDER NAME OR WORKMAN'S COMP: _____ DATE OF BIRTH: _____ AGE: _____
(FIRST) (LAST) (MIDDLE INT)

ADDRESS: _____ MALE _____ FEMALE _____

(CITY) (STATE) (ZIP CODE)

RELATIONSHIP TO PATIENT: _____ SPOUSE
_____ PARENT/GUARDIAN
_____ OTHER

EMPLOYER: _____ SS#: _____

EMPLOYER ADDRESS: _____ HOME PHONE: _____

(CITY) (STATE) (ZIP CODE)

WORK PHONE: _____ EXT: _____

W/C Claim # _____ Case Manager/Adjuster _____ Phone _____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician at MacNeal Health Network, the nurses, and staff, under their direction, to conduct such examinations, administer treatment and medications, as they deem necessary or advisable. I hereby authorize the release of any information acquired by this facility during the course of my examination and/or treatment to my employer, prospective employer, and/or insurance carrier as required.

DATE

SIGNATURE OF PATIENT/GUARDIAN