

# MACNEAL PHYSICIANS GROUP PATIENT INFORMATION

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
(FIRST) (LAST) (MIDDLE INT)

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_

ADDRESS: \_\_\_\_\_

MARITAL STATUS: \_\_\_ SINGLE  
 \_\_\_ MARRIED  
 \_\_\_ OTHER (WIDOW, DIVORCE, SEPARTED)

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

RACE: (check one)  
 \_\_\_ American Indian/Alaska Native \_\_\_ Middle Eastern/North African  
 \_\_\_ Asian/Oriental \_\_\_ White  
 \_\_\_ Black/African American \_\_\_ Other \_\_\_\_\_

SS#: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

ETHNICITY: (check one)  
 \_\_\_ Central American \_\_\_ Mexican  
 \_\_\_ Cuban \_\_\_ Not Hispanic or Latino  
 \_\_\_ Dominican \_\_\_ Puerto Rican  
 \_\_\_ Hispanic/Latino/Spanish \_\_\_ South American  
 \_\_\_ Latin American \_\_\_ Spaniard  
 \_\_\_ Other \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

CONTACT PREFERENCE:  
 \_\_\_ Home Phone \_\_\_ Cell/Mobile \_\_\_ Work Phone \_\_\_ Mail

EMAIL: \_\_\_\_\_

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

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

LAST DAY WORKED: \_\_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

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 \_\_\_\_\_