TCA HEALTH

1029 E. 130th Street · Chicago, IL 60628 · (773) 995-6300

PATIENT REGISTRATION FORM

1 Patient Information

Last Name **First Name**		**Gender: Female or Male**	**Date of Birth**	**SSN**
Address **City**	**State**	**Zip Code**		
Home Ph # ( ) **Marital Status** **S M W D SEP**	**Student Status** **F/P**	**Are you an Altgeld Murray (Garden) Resident? Yes or No** **Do you live in Public Housing? Yes or No**		
Cell Ph # ( )		**E-Mail Address:**		
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 Name:	**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 ( )**			

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

Last Name **First Name**		**Gender: Female /Male**	**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 # ( )**		

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

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 $**

4 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 in my behalf.

Signature_____ **Date:_____**