Atkinson Clinic S.C.
550 N Lake Street
Mundelein, IL 60060

Patient Registration Form

Patient Name _____ Home Phone _____
Email Address _____ Cell Phone _____
SS # _____ Date of Birth _____ Sex ◯ M ◯ F Marital Status ◯S ◯M ◯D ◯W
Home Address _____ City _____ State ___ Zip _____
Emergency Contact _____ Relationship _____ Phone _____
Name of Spouse/Parent _____ Phone_____ Referred By _____

In compliance with participation in a government program on patient quality of care we ask that you provide the following information:

Race: ◯ African-American ◯ American Indian ◯ Asian ◯ Caucasian ◯ Pacific Islander ◯ Unknown

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Unknown

Preferred Language: _____

Insurance Information (please submit insurance card(s) for copying
Primary Insurance _____ Subscriber's Name _____
Date of Birth _____ SS# _____ Relationship to patient _____
Secondary Insurance _____ Subscriber's Name _____
Date of Birth _____ SS# _____ Relationship to patient _____
Pharmacy Name and Phone _____

Assignment of Insurance Benefits: I hereby authorize direct payments of medical benefits to Atkinson Clinic S.C., for services rendered in the office. I understand that I am financially responsible for any balance not covered by my insurance. I further understand that if I default, and outside collection efforts are requested, I will be responsible for all collection fees, court costs, attorney fees, as well as any interest allowed by law.

Authorization of Release of Information: I hereby authorize Atkinson Clinic, S.C. to release any medical information pertaining to my treatment, and permit any insurance company / Medicare / Medicaid or its agents to inspect my medical records in connection with any charges arising from this treatment.

Cancellation Policy: If unable to keep my appointment I will give 24-hour notice.

We keep medical records in our archive for a period of 5 years. If you request a copy of your medical records, a reasonable charge will be assessed to cover the cost of copies and postage.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for any balance on my account for any professional services rendered. I have carefully read all of the information above, and answered all of the above questions. I certify that the information provided here is true and correct to the best of my knowledge.

I will notify you of any changes in my status or the above information.

I receive a copy of Atkinson Clinic, S.C. Patient Privacy Notice.

Signature: _____ Date: _____