CHICAGO CHEST CENTER
INTERVENTIONAL PULMONOLOGY & THORACIC DISEASE

SUBURBAN LUNG
SLEEP LUNG ALLERGY
ASSOCIATES

CHICAGO SLEEP GROUP

Name:		**Patient ID #:**	104075 **Sex:** [ ]M [ ]F
Address:		***Preferred Language**	
Address:		**Race**	
City,State, Zip:	,	**Ethnicity**	
Date of Birth:		**Preferred Method of Contact :** (Phone) (Letter) :	
Phone 1:	[ ]Home [ ]Work [X]Mobile	**e-Mail address**	
Phone 2:	[ ]Home [ ]Work [X]Mobile	**Referring Dr. & Phone:**	
Social Security #:		**Primary Dr. & Phone**	
Marital Status:	[ ]Married [ ]Single [ ]Divorced [ ] Widowed	**I authorize Release of Information to (you may designate 1 or 2 persons):**	
Emergency Contact	**Phone**	**ROI 1**	
		ROI 2	

RESPONSIBLE PARTY (If other than patient)

Name:		**Relationship to Patient**	[ ]Same as Patient
Address		**Social Security**	
City,State, Zip:		**Birthdate**	
Phone		**Employer:**	
Drivers License #		**Employer Phone**	

INSURANCE INFORMATION

PRIMARY INSURANCE:		***SECONDARY INSURANCE:***	
[ ]Patient [ ]Spouse [ ]Insured Party		[ ]Patient [ ]Spouse [ ]Insured Party	
Insured Party:		**Insured Party:**	
Ins Company:		**Ins Company:**	
Relationship to Patient:		**Relationship to Patient:**	
Social Security #:		**Social Security #:**	
Insured ID:		**Insured ID:**	
Policy Group:		**Policy Group:**	
Date of Birth:		**Date of Birth:**	
Insured Phone:		**Insured Phone:**	

I hereby authorize Suburban Lung Associates, SC to release any medical records related to my care in order to obtain payment for medical services rendered on my behalf. I also authorize Suburban Lung Associates, SC to submit all charges for services rendered to me and assign any benefits payable to Suburban Lung Associates, SC. I understand that I am responsible for any portion of my bill not covered by insurance companies, governmental agencies or their intermediaries, or third party payors. I understand that co-pays and balances are due at the time of the visit. This information is valid for (1) one year and will be updated annually. I have read and understand the Patient Responsibilities provided to me. **HIPAA** I hereby acknowledge receipt of the physician's Joint Privacy Notice. I understand that Suburban Lung Associates, SC has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature_____Date_____

* English is spoken by Staff. Please bring a translator if you need assistance.

02/24/2014