North Shore Endoscopy Center

101 S. Waukegan Road, Ste 980
Lake Bluff, IL 60044 Phone # 847-604-8700

PATIENT REGISTRATION FORM

PLEASE PRINT IN **BLUE OR BLACK INK,** FILL OUT ALL SECTIONS, **BRING THIS FORM, YOUR INSURANCE CARDS & PHOTO ID WITH YOU!**

PATIENT INFORMATION:
NAME (**Last**) ______________________ (**First**)______________________ (**Middle Initial)** __________

Address: ______________________ City:______________ County:__________ State______ Zip__________

Home # ______________________ Cell # ______________________ SEX: ☐ MALE ☐ FEMALE

DOB: _______/_______/________ AGE: ________ **SOCIAL SECURITY#** (FULL # or LAST **FOUR** DIGITS) _________ - _________ - __________

EMAIL Address: ______________________ MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Employer: ______________________ Work# ______________________ Ext________

Address: ______________________ **May we call you at work?** ☐ Yes ☐ No

***PRIMARY PHYSICIAN (s)** ______________________ Ph#______________ Fax#______________

***EMERGENCY CONTACT:** ______________________ Phone#______________________
Name Relationship

PRIMARY INSURANCE: ______________________ ID# ______________________ Group# ______________________

Claims Address ______________________ Ins Phone # ______________________

POLICY HOLDER: (**if other than SELF**) ☐ SPOUSE ☐ PARENT ☐ OTHER ______________________

Name______________________ DOB ________/__________/________ **SOCIAL SECURITY** ________-_________-________

Address ______________________ Phone # ______________________ ☐ Home ☐ Cell ☐ Work

SECONDARY INSURANCE: ______________________ ID# ______________________ Group# ______________________

Claims Address ______________________ Ins Phone # ______________________

POLICY HOLDER: (if other than SELF) ☐ SPOUSE ☐ PARENT ☐ OTHER ______________________

Name______________________ DOB _________/___________/________ **SOCIAL SECURITY** ________-________-________

Address ______________________ Phone # ______________________ ☐ Home ☐ Cell ☐ Work

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ADVANCED DIRECTIVES: Do you have a Living Will or Advanced Directives? ( ) Yes ( ) No
Would you like information about Advanced Medical Directives? ( ) Yes ( ) No Info Brochure given by______________________

ASSIGNMENT OF BENEFITS: I hereby assign benefits to be paid, on my behalf, to The North Shore Endoscopy Center for services rendered to me. I understand and agree to be financially responsible for all charges whether or not they are covered by insurance or other third party payors. In the event of default, I agree to pay all cost of collection and reasonable attorney fees.

RELEASE OF INFORMATION: I hereby authorize The North Shore Endoscopy Center to release all or part of my medical records when required for submission of any insurance claims for payment of services rendered by the center. The center, its agents, servants, and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

DISCLOSURE AGREEMENT: I have been informed that the physician who is rendering services may have an ownership interest in The North Shore Endoscopy Center. I have been given the option to be treated at another facility, which I have declined. I choose to be treated at The North Shore Endoscopy Center.

YOU MAY RECEIVE UP TO 4 SEPARATE STATEMENTS: The North Shore Endoscopy Center for the facility fee, your Physician for the professional fee, the Anesthesia Service for the anesthesia fee, and/or if your Physician orders any Lab or Pathology to be performed on specimens obtained during your visit to the center.

I agree that a photocopy of this agreement shall be valid as the original. I certify by my signature that I have read the foregoing and that I understand completely and fully accept the Terms specified therein.

Patient Signature______________________________________ **Date**______________________