



First Health Medical Center

1425 N McLean Blvd STE 550
Elgin, IL 60123

Tel: 630-550-1058 Fax: 866-538-8240

REGISTRATION FORM

(Please print)

Today's Date:		PCP: <input type="checkbox"/> PCP Deepak Sharma FNP-BC	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms.	
		Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name?	If not, what is your legal name?	(former name):	Birth Date: Age: Sex:
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> M <input type="checkbox"/> F
Street address :		Home phone number: ()	
City:		Mobile phone number: ()	
State:		Work phone number: ()	
ZIP Code:		Email address: @	
PHARMACY PREFERENCE			
Preferred local Pharmacy:	Town – Location of Pharmacy:	Closet Intersection to Pharmacy:	
Preferred Mail Order Pharmacy:			
<input type="checkbox"/> Express Script <input type="checkbox"/> Prime Mail <input type="checkbox"/> Prime Therapeutics <input type="checkbox"/> CVS Caremark <input type="checkbox"/> Aetna Home Delivery			
<input type="checkbox"/> Other:			
Chose clinic because/referred to clinic by (Please check one box):			
<input type="checkbox"/> Family	<input type="checkbox"/> Location	<input type="checkbox"/> Friend:	<input type="checkbox"/> Internet <input type="checkbox"/> Referred by Doctor:
<input type="checkbox"/> Hospital /Referral line	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Other:	
Other family members seen here:			
IN CASE OF EMERGENCY			
Name for local Emergency Contact:	Relationship to patient:	Mobile phone no:	Home/Work phone no.:
1)		()	()
2)		()	()
FOLLOWING INDIVIDUALS SHALL HAVE ACCESS MEDICAL INFORMATION			
Name of Individual:	Relation to patient:		
1)			
2)			
3)			
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize First Health Medical Center to release any information required to process my claims for payment.			
Patient or Legal Guardian Signature		Date	