Aavanced Allergists, Ltd.

800 W. Biesterfield Road #4002
Elk Grove Village, IL 60007
(847) 364-0028

Golf Mill Professional Building
241 Golf Mill Center #820
Niles, IL 60714
(847) 298-5151

455 South Roselle
Schaumburg, IL 60193
(847) 352-2822

504 S. Rand Road
Lake Zurich, IL 60047
(847) 438-0760

PATIENT'S NAME _____

PATIENT'S ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

PATIENT'S BIRTHDATE _____ ☐ MALE ☐ FEMALE

PATIENT RELATIONSHIP TO INSURED: _____

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PATIENT STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

☐ EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

REFERRED BY _____

ADDRESS _____ CITY _____ ZIP _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

TELEPHONE (Include Area Code) _____

PRIMARY INSURANCE

INSURED'S S.S. NUMBER _____

INSURED'S NAME _____

INSURED'S ADDRESS _____

CITY _____ STATE _____

ZIP CODE _____ TELEPHONE _____

INSURED'S POLICY GROUP OR FECA NUMBER

_____

INSURED'S DATE OF BIRTH _____ ☐ MALE ☐ FEMALE

EMPLOYER'S NAME WORK PHONE

_____ _____

INSURANCE PLAN NAME OR PROGRAM NAME

_____

IS THERE ANOTHER HEALTH BENEFIT PLAN ? ☐ YES ☐ NO

SECONDARY INSURANCE

INSURED'S NAME _____

INSURED'S POLICY OR GROUP NUMBER

_____

INSURED'S DATE OF BIRTH _____

☐ MALE ☐ FEMALE

EMPLOYER NAME OR SCHOOL NAME

_____

INSURANCE PLAN NAME OR PROGRAM NAME

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment and/or medical benefits to the undersigned physician. I authorize you to give me reasonable and proper medical care by today's standards.

_____

SIGNED DATE