



### HealthPartners

Website: wellgroup.org

Employee Initials \_\_\_\_\_

Record No. \_\_\_\_\_

Acct. No. \_\_\_\_\_

## PATIENT INFORMATION FORM

333 Dixie Hwy.  
Chicago Heights  
Illinois 60411-1748

10043 Lincoln Hwy.  
Frankfort  
Illinois 60423-1272

20939 S. Cicero Ave.  
Matteson  
Illinois 60443-1620

19807 LaGrange Road  
Mokena  
Illinois 60448-8348

3700 W. 203rd. St.  
Suite 301  
Olympia Fields  
Illinois 60461-1182

3800 W. 203rd. St.  
Suite 204  
Olympia Fields  
Illinois 60461-1178

3900 W. 203rd. St.  
Olympia Fields  
Illinois 60461-2253

30 E. 15th St.  
Suite 306  
Chicago Heights  
Illinois 60411-3459

PATIENT NAME		DATE OF BIRTH		TODAY'S DATE	
ADDRESS		CITY		STATE	ZIP CODE
<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	MARITAL STATUS	SOCIAL SECURITY NO.	PHONE NO. (S) Home (    ) Work (    )	Cell/Other (    )	

**RESPONSIBLE PARTY (If you are the responsible party, omit this section)**

NAME		SOCIAL SECURITY		DATE OF BIRTH	
ADDRESS		CITY		STATE	ZIP CODE

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME		GROUP NO.	EFFECTIVE DATE	I.D.# OR SOCIAL SEC.# (NOT POLICY #)	
ADDRESS		CITY		STATE	ZIP CODE
SUBSCRIBER'S NAME		DATE OF BIRTH	RELATIONSHIP TO PATIENT	EMPLOYER	
SECONDARY INSURANCE COMPANY NAME		GROUP NO.	EFFECTIVE DATE	I.D.# OR SOCIAL SEC.# (NOT POLICY #)	
ADDRESS		CITY		STATE	ZIP CODE
SUBSCRIBER'S NAME		DATE OF BIRTH	RELATIONSHIP TO PATIENT	EMPLOYER	

**Authorization:** I hereby authorize WellGroup HealthPartners, to furnish my health insurance company all the information which said insurance company may request concerning treatment for myself or my dependents. I hereby assign to the WellGroup HealthPartners the medical and/or surgical benefits to which I or my dependents are entitled under my health insurance and/or Medicare benefits.

**Financial Responsibility:** I understand that I am responsible for any services or supplies that may not be covered under my insurance plan. I hereby understand that there will be a 1.5% / month service charge (18%/annum) added to all balances over 90 days old.

Signature X \_\_\_\_\_ Date: \_\_\_\_\_

Item No. 860-1150 (06/04)

**NEW PATIENTS:** How did you hear about WellGroup HealthPartners?

Radio / TV     Newspaper     Word of mouth     Newsletter     Physician referral

Insurance provider     Seminar/education program     New movers program     Sign/billboard

Direct Mail     Website     Yellow Pages     Other: \_\_\_\_\_

Please provide your Insurance Card to the WellGroup HealthPartners staff member for copy.