Michael Lesser, M.D.

Family Nurse Practitioner
Cindy MacDonald, C.N.P.
Christy Benton, C.N.P.
Katherine Galias, C.N.P.

FAMILY MEDICINE
FOR McHENRY COUNTY

PATIENT REGISTRATION

Patient's Name: First: _____ Middle: _____ Last: _____

Birth date: ____/____/____ Sex: M / F Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ How did you hear about us? _____

Preferred Contact By: Phone Email Letter Preferred Language: English Spanish Other: _____

Race: (1) Caucasion (2) Hispanic (3) African American (4) Other: _____

Ethnicity: (1) Hispanic or Latino (2) Non-Hispanic or Latino (3) Other: _____

EMERGENCY CONTACT

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to Patient _____

PERSON RESPONSIBLE FOR BILL

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship: Self / Spouse / Child / Other: _____ Birth date: ____/____/____ Sex: M / F

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group: _____

Policyholder's Name (Person who carries insurance): _____ Birthdate: ____/____/____ Sex: M / F

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Relation to Policyholder: Self / Spouse / Child / Other: _____

Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group: _____

Policyholder's Name (Person who carries insurance): _____ Birthdate: ____/____/____ Sex: M / F

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Relation to Policyholder: Self / Spouse / Child / Other: _____

Employer: _____

I, the undersigned, assign directly to Family Medicine for McHenry County all benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signed _____ Date ____/____/____

Your insurance card and copayment are due at each visit. Pease notify the office of any changes.