Primary Care Associates
6840 W. Windsor
Berwyn, Il 60402
(Please complete Both Sheets and Sign)

Primary Physician:_____ **Date:** _____

Patient Name: _____ Sex: M F
Address: _____ Marital Status: M S D W
City, State, Zip: _____ Birth date: ____/_____/_____
Home phone: _____ SS# _____
Cell#: _____

Name of Emergency Contact, Spouse, Parent or Guardian: _____ Relationship_____
Address_____ Home#_____ Cell#_____ Work#_____

Policyholder/guarantor information (Individual Responsible For Your Bill)
Name: _____ Address: _____
Relationship: _____ SS# _____ Birthdate: _____
Employer:_____ Employer Address: _____

Insurance Information
Primary plan name: _____
Policy ID# _____ Policy Group # _____
Secondary plan name: _____
Policy ID# _____ Policy Group# _____

Insurance assignment
I authorize payment from any insurance company or government agency to be paid directly to Primary Care Associates In some cases payment may not cover the entire fee and a bill for the balance will be sent to me.
Signature: _____

I give authorization to the following people to receive my protected health/medical information.
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Additionally, the physicians or nursing staff may need to speak with you regarding medical issues. Please indicate Below where/with whom they can leave messages. Please include phone number if not previously given.
Home answering system YES _____NO_____ Number: _____
Work voice mail YES _____NO_____ Number: _____
My cell phone YES _____NO_____ Number: _____

Preferred E-Mail Address: _____

ACKNOWLEDGEMENT OF RECEIPT OR KNOWLEDGE OF PRIMARY CARE ASSOCIATES PRIVACY NOTICE.
I, _____, acknowledge that I have either been given or have been made aware of the Primary Care Associates, "Notice of Privacy Practices." I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.
Signature: _____ Date: _____

*We may occasionally review your prescription history by electronic means. If you do or do not want to give us permission to access your electronic histories please sign and date here:
I give my permission: _____ I do not give my permission:_____

Signature:_____ Date: _____

List Dependents Who are PCA Patients *Under* 18 Years of Age

Name: _____Birth Date: _____Social Security:_____
Name: _____Birth Date: _____Social Security:_____
Name: _____Birth Date: _____Social Security:_____
Name: _____Birth Date: _____Social Security:_____

I give authorization to the following people to receive above minor's protected health/medical information.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship:_____

Emergency Contact:
Name_____ Relationship: _____
Home phone: _____ Cell phone: _____
Work phone: _____

The physicians or nursing staff may need to speak to you regarding medical issues pertaining to your minor children listed above. Please indicate below where/with whom they can leave messages. Please include phone numbers.

1. Home answering system YES_____NO_____ Number:_____

2. Cell phone YES_____NO_____ Number:_____
   Relationship to patient: _____

3. Work voice mail YES_____NO_____ Number:_____
   Relationship to patient: _____

If you signed this as a personal representative on behalf of an individual, complete the following:

Personal representative's name: _____
Signature: _____
Relationship: _____
Patient date of birth: _____

Email address for above listed minors: _____