The Medical Group of Kankakee County
Patient Information Sheet

Last Name _____ First Name _____ Middle Name _____ Date of Birth _____

Social Security # _____ Gender _____ Marital Status _____ Race _____ Ethnicity _____ Language _____

Please indicate a preferred method of telephone contact by selecting box.

☐ (Area Code)Home Phone _____ ☐ (Area code) Work Phone _____ ☐ (Area Code) Cellular phone _____

Home Address _____ City _____ State _____ Zip Code _____

Confidential Email Address _____ Home Phone - Cell Phone - Patient Portal
Preferred Reminder Method - please circle one

Employer _____ Occupation (FT/PT) _____ Employer city,state _____

Primary Care Physician _____ How did you hear about our practice? _____

Guarantor Information (Person Responsible for Bill)

Last Name _____ First Name _____ Middle Name _____

Relationship to Patient _____ Guarantor's Date of Birth _____ Social Security Number _____

(Area Code)Home Phone _____ (Area code) Work Phone _____ (Area Code) Cellular phone _____

Home Address _____ City _____ State _____ Zip Code _____

Emergency Contact

Name _____ Relationship _____ (Area code) Phone Number _____

Signature of Patient or Guardian _____ Date _____

Primary Insurance Information

Insurance Company Name | Insurance Co. Phone Number | Employer

Claim's Address | City | State | Zip Code

ID# | Group#

Policy Holder's Name | Social Security Number | Date of Birth | Relation to Patient

Secondary Insurance Information

Insurance Company Name | Insurance Co. Phone Number | Employer

Claim's Address | City | State | Zip Code

ID# | Group# | Employer

Policy Holder's Name | Social Security Number | Date of Birth | Relation to Patient

Please present insurance card to the receptionist so a copy can be made for your file.

Payment of Benefits

I direct payment to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charge for those services.

Signature of Insured | Date

Assignment and Release of Information

I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize release of any information relating to my treatment for insurance purposes. I authorize the use of this signature on all insurance or other health care providers submissions.

Signature of Insured | Date

01/16 Form Staff initials_____