Perry L. Kamel, M.D., S.C.
259 East Erie Street, Suite 1600
Chicago, IL 60611
Fax: 312-573-9636
312-573-9626

Our office policy requires payment for all medical services at the time of visit, unless other arrangements have been made with the business manager.

Date ____________________

PATIENT INFORMATION (PLEASE PRINT)

NAME: ____________________ DATE OF BIRTH: ____________________

ADDRESS: ____________________ HOME# ( ) ____________________

CITY: ____________ STATE: ________ ZIP________ WORK# ( ) ____________________

SOCIAL SECURITY #____________________SEX:________ CELL# ( ) ____________________

REFERRED BY: ____________________ MARITAL STATUS: S M D W SEP PART

PATIENT'S EMPLOYMENT INFORMATION

EMPLOYER: ____________________ OCCUPATION: ____________________

ADDRESS: ____________________CITY:____________ STATE: ________ ZIP: ____________

SPOUSE/PARTNER'S INFORMATION

SPOUSE/PARTNER'S NAME: ____________________ SS# ____________________

EMPLOYER: ____________________ WORK# ( ) ____________________

ADDITIONAL INFORMATION

YOUR PHARMACY: ____________________ PHONE# ( ) ____________________

RESPONSIBLE PARTY: ❑ SELF ❑ SPOUSE ❑ PARENT ❑ PARTNER NAME ____________________

INSURANCE INFORMATION

ALL INFORMATION MUST BE COMPLETED OR WE CANNOT SUBMIT YOUR FEE TO YOUR INSURANCE COMPANY

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Policy Holder: ____________________	Policy Holder ____________________
Relationship to Patient: ____________DOB________	Relationship to Patient: ____________ DOB______
Insurance Co. Name: ____________________	Insurance Co. Name: ____________________
Address: ____________________	Address: ____________________
City: ____________ State _______ Zip ________	City: ____________ State _______ Zip _______
ID# ____________ Group# ____________	ID# ____________ Group# _________

I hereby authorize Perry L. Kamel, M.D., S.C. to furnish information to my insurance carriers concerning my treatments and illness, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependants. **I understand that I am responsible for any amount not covered by my insurance(s).**

SIGNATURE____________________________________ DATE____________________
(Patient and/or guardian, if minor)

Please complete this Patient Information Form and ***fax*** *or* ***mail*** *back with a* ***copy of the front and back of your insurance card as soon as possible****.*