

*Southern Illinois Sports Medicine*

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**REGISTRATION INFORMATION**

DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

First Middle Initial Last

PATIENT'S SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX \_\_\_ M \_\_\_ F

PATIENT'S ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ OTHER PHONE# \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED

PERSON RESPONSIBLE FOR BILL \_\_\_\_\_ SS# \_\_\_\_\_

(GUARANTOR)

GUARANTOR'S ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

PATIENT'S OCCUPATION \_\_\_\_\_ FULL TIME STUDENT \_\_\_ YES \_\_\_ NO

PATIENT'S EMPLOYER \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

SPOUSE'S BIRTHDATE \_\_\_\_\_ SPOUSE'S SOCIAL SECURITY # \_\_\_\_\_

EMERGENCY CONTACT (OTHER THAN SPOUSE) \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ PHONE \_\_\_\_\_

MEDICARE # \_\_\_\_\_ IS MEDICARE PRIMARY \_\_\_ YES \_\_\_ NO

IL PUBLIC AID # \_\_\_\_\_ **CARD MUST BE WITH YOU AT TIME OF VISIT**

PRIMARY INSURANCE CO. NAME \_\_\_\_\_

NAME OF INSURED (IF OTHER THAN PATIENT) \_\_\_\_\_

ADDRESS OF INSURED \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTHDATE OF INSURED \_\_\_\_\_

EMPLOYER/SUBSCRIBER'S NAME \_\_\_\_\_ SS# OF INSURED \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

SECONDARY INSURANCE CO. NAME \_\_\_\_\_

NAME OF INSURED (IF OTHER THAN PATIENT) \_\_\_\_\_

ADDRESS OF INSURED \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTHDATE OF INSURED \_\_\_\_\_

EMPLOYER/SUBSCRIBER'S NAME \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
First Middle Initial Last

**PLEASE BRING ALL INSURANCE CARDS TO WINDOW**

REFERRING PHYSICIAN \_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with insurer).

**IN ORDER TO HELP CONTROL THE COST OF BILLING, WE REQUEST PAYMENT BE MADE FOR ALL OFFICE SERVICES AT THE CONCLUSION OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.**

**MEDICARE/HEALTH INSURANCE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare/Health Insurance benefit be made on my behalf to Healthcare Physicians of Southern Illinois, P.C. for any services furnished to me by the physician. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Signature \_\_\_\_\_ D.O.B \_\_\_\_\_ Date \_\_\_\_\_