3033 Ogden Ave., Suite 210
Lisle, IL 60532

PAUL J. CAPRIOTTI, M.D. AND ASSOCIATES
REGISTRATION FORM

PATIENT INFORMATION

Patient Name:_____
First Middle Initial Last

Patient Address:_____

City _____ State _____ Zip _____

Patient Telephone Numbers:

Home (_____)_____ Patient Social Security # _____

Business (_____)_____ Patient Date of Birth _____

Cell (_____)_____ Patient Gender Male Female

Patient Marital Status:

Married Single Divorced Separated Widow

Employed Yes No Full Time Student Part Time Student

Patient Employer or School _____Patient Occupation _____

Patient Religion _____ Practicing Non Practicing

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Ins Co Name_____	Ins Co Name_____
Subscriber Name _____	Subscriber Name _____
Subscriber Date of Birth _____	Subscriber Date of Birth _____
Subscriber Social Security # _____	Subscriber Social Security # _____
Identification # _____	Identification # _____
Group # _____	Group # _____
Employer _____	Employer _____

GUARANTOR INFORMATION

Name _____ Social Security # _____
First Middle Initial Last

Address (if different than patient) _____ Date of Birth _____

City _____ State _____ Zip _____

Guarantor Phone Numbers:

Home (_____)_____ Business (_____)_____ Cell (_____)_____

Patient Relationship to Insured : Self Spouse Child Other

Please Complete Both Sides

Do you have any of the following?

Durable Power of Attorney for Healthcare?	No	Yes
Living Will?	No	Yes
Declaration for Mental Health Treatment?	No	Yes

EMERGENCY CONTACT INFORMATION

(Different from Home)

Name _____ Relationship to Patient _____

Address _____ Telephone (_____)_____

PRIMARY CARE PHYSICIAN

Name or Group _____

Address _____Telephone (_____)_____

REFERRAL INFORMATION

Name of Referring Person or Organization _____

Address _____ Telephone (_____)_____

Physician	Therapist/Counselor	Hospital	School
Insurance	Friend/Relative	Phone Book	Other

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

Acknowledgement of Patient Rights
I acknowledge that I have read my Patient Rights.

Acknowledgement of Privacy Rights
I acknowledge that I have read the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Assignment of Insurance Benefits
I authorize the assignment of benefits payable to Paul J. Capriotti, MD and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

Authorization for Additional Fees
In the event any lawsuit or action is brought to collection, this account or any portion thereof, the patient/guarantor will be responsible for any and all costs not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

Authorization for Treatment
I freely and knowingly agree and give my express consent to the performance of such procedures for the purpose of clinical observation, and/or administration of whatever medications, or simple laboratory tests as may be considered necessary or desirable, in the observation, diagnosis, and treatment of my case by the physician or staff of the clinic. I give my consent for mental health and/or addictions treatment in the clinic of Paul J. Capriotti, M.D. and Associates. I am aware that the practice of medicine is no an exact science and further state that no guarantee has been or can be made as to the results of the treatments or examinations in the clinic. I declare that I have provided or will provide financial, family and medical history information requested to the best of my knowledge, and believe that such information given is true, correct and complete.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/ Legal Guardian Date

_____ _____
Witness Date

Please Complete Both Sides