



850 S. Wabash Ave., Suite 210
Chicago, IL 60605

(312) 942-5100 Office
(312) 942-5109 Fax

Patient Information

Name: _____

Date of Birth: ____/____/____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Email communication will be sent encrypted unless specified. I prefer unencrypted emails.

Preferred contact method: Email US Mail

Gender: Male Female

Preferred Phone: _____ Home Mobile Work Other

Secondary Phone: _____ Home Mobile Work Other

Other Phone: _____ Home Mobile Work Other

Referred by: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Marital Status: Married Single Divorced Widowed Other

Race: American Indian or Alaskan Native Asian or Pacific Islander African-American Caucasian

Refuse to Report

Ethnicity: _____ Hispanic Non-Hispanic Refuse to Report

Primary Language: English Spanish Other _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE PLAN

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Insurance policy holder: Spouse Child Self Other: _____

Policy Holder Name: _____ Policy Holder Gender: Female Male

Date of Birth: ____/____/____ Social Security Number: _____

SECONDARY INSURANCE PLAN (IF ANY)

Payer (e.g. BC/BS): _____ Plan: _____
Policy/I.D. Number: _____ Group Number: _____
Insurance policy holder: Spouse Child Self Other: _____
Policy Holder Name: _____ Policy Holder Gender: Female Male
Date of Birth: ____/____/____ Social Security Number: _____

I certify that the above information is accurate, complete and true. I understand that this will become part of my medical record. In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize David R. Buyer, MD to submit to my insurance carrier claims for services rendered and I direct my insurance carrier to issue payment directly to David R. Buyer, MD. I recognize and accept responsibility for any balance remaining after payment by my insurance company.

Patient Signature Printed Name Date

Parent/Guardian Signature Printed Name Date