QUINTESSENTIAL care

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

4905 Old Orchard Rd., Suite 634
Skokie, IL 60077

(312) 598-3520 *Office*
(312) 598-3525 *Fax*

Patient Information

Name: _____

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

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Gender: ☐ Male ☐ Female

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work ☐ Other

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work ☐ Other

Other Phone: _____ ☐ Home ☐ Mobile ☐ Work ☐ Other

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 authorizations for payment for outside services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize Quintessential Care to submit to my insurance carrier prior authorizations for outside services.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date