Patient#_____ Office___ J=Joliet Date_____

Name_____
Address_____
Street City State Zip
Phone#_____/_____ _____
Home Cell / Business Email Address
Marital Status____ M=Married S=Single W=Widow D=Divorced
S.S.#_____Birthdate___/___/___ Sex___

Relation To Insured ___ 1=Self 2=Spouse 3=Son 4=Daughter 5=Other
Insured Name_____ Insured S.S.#_____
Insured Address_____
Street City State Zip
Insured Birthdate___/___/___ Insured Sex___
Insured Employer_____

	Format	Group/Policy #	Co. Name/Address
Ins. Co. 1	_____	_____	_____
Ins. Co. 2	_____	_____	_____

Credit Card: - Do you want to pay by Credit Card? Yes or No

Referred By: Name/Phone #_____

Family/Referring Physician _____
Address_____
Phone #_____Fax #_____

Allergies_____ Current Medication_____

Are you pregnant? Yes or No

Please check if you have any of the following illnesses: _____None
____Heart Ailments ____Epilepsy ____Gout ___Hypertension
____Varicose Veins ____Arthritis ____Hepatitis ___Diabetes

Authorization is hereby granted for such treatment and procedures as deemed necessary. I authorize Daniel JE Helmer DMP PC to bill my Medicare, Medicaid, Blue Cross/Blue Shield, or any other health insurance coverage I may have on my behalf.

By signing below I acknowledge Receipt of Notice of Privacy Practices.

_____

Signature of Patient or Person Authorized to Consent Date