

Peoria Surgical Group

Welcome to Our Practice

As a new patient or a renewing patient, please fill out the information found below to the best of your ability.

Patient Name (first, middle, last)		Social Security No.	Date		
Address		City/State/Zip	Primary Phone # (w/ area code)		
Male/Female	Age	Date of Birth	1st Alternate # (w/ area code)		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			2nd Alternate # (w/ area code)		
Employer Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled					
Employer & Occupation					
Primary Care Physician					
Referring Provider (if different than Primary Care)					
Name of preferred Pharmacy		Address/City/State/Zip	Telephone		
Which Hospital do you or your insurance prefer for your surgical needs? (Circle the appropriate one)					
OSF		Unity Point Methodist	Unity Point Proctor		
Which hospital or lab do you or your insurance prefer for testing to be sent to? (Circle the appropriate one)					
OSF		Unity Point Methodist	Unity Point Proctor	LabCorp	Quest

Primary Insurance Information

Insurance Company Name

Policy Holders SS#	GROUP #	MEMBER ID#
Policy Holders Name (first, middle, last)		Relationship to Patient & DOB
Policy Holder's Address (if different than patient)		City / State / Zip

Secondary Insurance Information

Insurance Company Name

Policy Holders SS#	GROUP #	MEMBER ID#
Policy Holders Name (first, middle, last)		Relationship to Patient & DOB
Policy Holder's Address (if different than patient)		City / State / Zip

Workman's Comp Information

Were you hurt on the job?	YES	NO	Date of injury:	/	/
Name of Employer / Company where you were when you were hurt					
Contact Person			Contact #		
Claim #		Name of W/C Insurance Company			
Address			City / State / Zip		
Last Date Worked		Date returned to work			
/ /		/ /			

(Please give insurance card(s) to receptionist to make a copy)

