Woodridge Clinic

Woodridge Clinic
7530 S. Woodward Ave.
Woodridge, IL 60517
Phone: (630) 910-1177
Fax: (630) 910-6995

Woodridge Clinic - Lemont
15884 W. 127th Street, Suite H
Lemont, IL 60439
Phone: (630) 754-8710
Fax: (630) 910-6995

Woodridge Clinic - Lombard
805 S. Main Street
Lombard, IL 60148
Phone: (630) 620-6225
Fax: (630) 620-6286

REGISTRATION FORM

Patient Name _____ **DOB** _____

Race
- ☐ Asian Indian / Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Multi-Racial
- ☐ Other Race
- ☐ Prefer Not to Answer

Ethnicity
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer Not to Answer

(State and Local governments may use the data to help plan and administer bilingual programs for people of Hispanic origin.)

Preferred Language
- ☐ Albanian
- ☐ American Sign Language
- ☐ Amharic
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Bulgarian
- ☐ Burmese
- ☐ Cambodian
- ☐ Cantonese
- ☐ Chin
- ☐ Chinese
- ☐ Creole
- ☐ Czechoslovakian
- ☐ Dutch
- ☐ English
- ☐ Farsi
- ☐ Filipino
- ☐ Flemish
- ☐ French
- ☐ German
- ☐ Ghana
- ☐ Greek
- ☐ Gujarati
- ☐ Hebrew
- ☐ Hindi
- ☐ Hungarian
- ☐ Ilocano
- ☐ Italian
- ☐ Japanese
- ☐ Karen
- ☐ Khmer
- ☐ Korean
- ☐ Laotian
- ☐ Lithuanian
- ☐ Malayalam
- ☐ Mandarin
- ☐ Marathi
- ☐ Norwegian
- ☐ Other/Not listed
- ☐ Pakistan
- ☐ Pashto
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Pt. Declined
- ☐ Punjabi
- ☐ Romanian
- ☐ Russian
- ☐ Serbian
- ☐ Other/Not listed
- ☐ Pakistan
- ☐ Pashto
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Pt. Declined
- ☐ Punjabi
- ☐ Romanian
- ☐ Russian
- ☐ Serbian
- ☐ Shanghai
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Taiwanese
- ☐ Tamil
- ☐ Telugu
- ☐ Thai
- ☐ Tigrina
- ☐ Turkish
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yugoslavian

Preferred Pharmacy _____ Telephone Number _____

Intersection / Cross Streets _____

PERSON TO NOTIFY IN EMERGENCY

Name _____

Relationship to Patient _____

Sex M / F DOB _____

Home Phone (___) _____

Work Phone (___) _____

Cell Phone (___) _____

_____ _____
Patient Signature Date

_____ _____
Signature of Authorized Person Date

Woodridge Clinic

REGISTRATION FORM (contd.)

PATIENT INFORMATION

Patient's Legal Name _____ DOB _____

Is address on ID current? ☐ Yes ☐ No If no, please enter current address below.

Current Address

_____

_____

_____ _____
Zip Code

Home Phone (___) _____

Work Phone (___) _____

Cell Phone (___) _____

Preferred Phone (mark box below)
☐ Home ☐ Work ☐ Cell

Employment Status
☐ Full Time ☐ Retired
☐ Part Time ☐ Military Duty
☐ Not Employed
☐ Self Employed

Sex
☐ Male
☐ Female

Martial Status
☐ Single
☐ Married
☐ Divorced
☐ Widow/Widower
☐ Separated

Email Address _____

How did you hear about this clinic? _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT
(GUARANTOR IF PATIENT IS UNDER 18 YRS OF AGE)

☐ Same as patient DOB _____ Sex M / F

Legal Name _____

☐ Address is same as patient

Street _____ Apt # _____

City _____ State _____ Zip Code _____

Relationship to Patient _____

PERSON WHO CARRIES THE INSURANCE FOR THE PATIENT
(SUBSCRIBER)

☐ Same as patient DOB _____ Sex M / F

Legal Name _____

☐ Address is same as patient

Street _____ Apt # _____

City _____ State _____ Zip Code _____

Relationship to Patient _____

Social Security Number _____
The subscriber's social security number is required for on line billing.