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: _____

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