



A division of: **AIC**
325 Tamarack Lane / Shiloh, IL 62269 // 2023 Vadalabene Drive / Suite 151 / Maryville, IL 62062
(618) 250-4688 / Fax (618) 624-2226 / www.quellheadache.com / info@quellheadache.com

Date: _____

Patient Information

Name (Last, First, MI): _____

Gender (circle): Male / Female / Other

Race (circle): Asian / Native Hawaiian / Pacific Islander / African American / White / Hispanic / Other / Prefer not to answer

Marital Status (circle one): Married / Partner / Single / Widowed / Divorced / Separated

Social Security Number: _____ DOB: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Mobile: _____ Work: _____

Where may we leave a message, including private health information (check all that apply)? Home Mobile Work

E-mail Address: _____

Insured Information

Name of Insured: _____

Relationship to Patient (Self, Parent, Spouse or Other): _____

Insured Parent, Spouse or Other's Date of Birth: _____

Insured Parent, Spouse or Other's Social Security Number: _____

Insurance Information

Primary Insurance:

Company: _____

Member: _____

Policy Number: _____

Group Number: _____

Secondary Insurance:

Company: _____

Member: _____

Policy Number: _____

Group Number: _____

Physician Information

Physician requesting consult (referring physician): _____ Phone: _____

Primary care physician: _____ Phone: _____

Pharmacy Information

Local Pharmacy: _____ Address: _____

Mail Order Pharmacy: _____ Mail Order Pharmacy Fax: _____

May we electronically access your prescription history? Yes No

Emergency Notification / Legal Guardian / Next of Kin (circle one)

Name: _____

Relationship: _____

Home Telephone: _____

Cell Phone: _____

May medical information be released to this individual? Yes No

I understand that this authorization may be withdrawn or revised by myself in writing at any time.

How did you learn about our practice? (Please check all that apply)

- Physician Referral** (Name: _____)
- Family Member** (Name: _____ Relationship: _____)
- Relative** (Name: _____ Relationship: _____)
- Friend** (Name: _____)
- Advertisement (circle) – Google / Facebook / Print (home mailer, newspaper) / AAIC website / Other: (Please list source of advertisement or name of mailer if known)** _____

Patient Information Signature Page:

Patient Signature: _____ Parent or Guardian Signature (for minor): _____

Relation to patient: _____ Date: _____