Midwest Wellness Center Associates
Shalini Chawla MD LLC

519 N Cass Ave, Suite 204, Westmont, IL 60559; PH: (630) 541-9560; Fax: (630) 541-8381
3000 N Halsted St, Suite709, Chicago, IL 60657; Ph: 773-698-6417 Fax: 773-698-6496
www.midwestwellnessca.com

PATIENT REGISTRATION FORM

Patient Name _____ Date of Birth _____/_____/_____ F

Parent / Guardian Name (s) _____

Address _____ City _____

State _____ Zip Code _____

Home Phone _____ Work / Cell Phone _____

Religion _____Email _____

PRIMARY CARE PHYSICIAN

Primary Care Physician _____ Phone _____

Office address _____ City _____

State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance

Insured's Name _____

DOB: _____ SS #_____

Employer _____

Insurance _____

ID _____ Group _____

Secondary Insurance

Insured's Name _____

DOB: _____ SS# _____

Employer _____

Insurance _____

ID _____ Group _____

I (we) hereby volunteer to such diagnostic and therapeutic procedures, which may be ordered or deemed advisable by my/my child's attending physician or his/her designee. I agree to assign insurance benefits to the treating physician. Medical Information may be released to my insurance company for the purpose of securing payment for services received; and understand any procedures NOT covered by my insurance or unpaid portions are my responsibility and will be paid in full within 90 days of receiving a bill from the medical provider.

X _____ Date _____

Please check one: ☐ Patient ☐ Parent ☐ Legal Guardian