Colette Gordon M.D. and Associate
2800 North Sheridan Road, Suite 101
Chicago, IL 60657
(773) 271-7835

Please complete this form in it's entirety. ***PRINT CLEARLY.***

Patients Name: ____

Parent or Guardian (If under 18): ____

Street Address (No PO Boxes): ____

City:____________________________________ State: _____________ Zip Code:_____________

Date of Birth: _______/_______/_______ Social Security Number: _______-_______-_______

Gender (Circle One): Male Female **Email:**_____________________________________

Cell Phone:______________ **Home Phone:** ______________ **Work Phone:** ______________

Company you work for: ____

Are you insured or are you a self pay patient? _______ Insured _______ Self Pay

Primary Insurance Company: ____

Policy ID: _________________ Group# _________________ Effective Date: ______________

Secondary Insurance: ____

Policy ID: ________________ Group# _________________ Effective Date: _______________

Emergency Contact First Name: ____

Emergency Contact Last Name: ____

Emergency Contact Relationship: ________________ Phone# _____________________________

______ Hispanic or Latino ______ Not Hispanic or Latino ______ I decline to specify

Race: ______American Indian or Alaska Native ______Asian _______White

_______Black or African American _______Native Hawaiian or Pacific Islander

_______I decline to answer Preferred Language: _________________________

Sign: ____ Date: _______________________