Marius J. Katilius, M.D. ♦ Jonathan C. Wu, M.D.
Phone: 815-744-0330 ♦ FAX: 815-744-0445

WELCOME TO OUR OFFICE

DATE:_____
NAME:_____ DOB:_____ AGE:_____
ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____
PHONE:_____ SS#:_____ MARITAL STATUS: ◯S ◯M ◯D ◯W
OCCUPATION:_____ EMPLOYER:_____
ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____
WORK #:_____ CELL #:_____ EMAIL ADDRESS:_____

COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

RESPONSIBLE PARTY:_____ RELATIONSHIP:_____
ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____
PHONE:_____ DOB:_____ SS#:_____
OCCUPATION:_____ EMPLOYER:_____ PHONE:_____
ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____
'IN CASE OF EMERGENCY' CONTACT:_____ RELATIONSHIP:_____
PHONE:_____ ADDRESS:_____ CITY:_____ STATE:___ ZIP:_____
WHO REFERRED YOU TO THIS OFFICE:_____
DO YOU HAVE AN ANSWERING MACHINE: ◯Y ◯N
~IF YES, MAYWE LEAVE A MESSAGE ON IT REGARDING CALLBACKS: ◯Y ◯N

WE MUST HAVE A COPY OF YOUR INSURANCE CARD IN YOUR CHART

IF YOU ARE MARRIED, PLEASE COMPLETE THIS SECTION

NAME:_____ DOB:_____ SS#:_____
OCCUPATION:_____ EMPLOYER:_____ PHONE:_____
ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

I AUTHORIZE:

1. the physician and staff to perform any medical treatment or care deemed necessary
2. the release of any medical information necessary to process medical claims
3. the payment of medical benefits to this office.

_____ _____
Signature of Patient or Guardian if Minor Date