



Theri Griego Raby, MD, ABHM
RABY INSTITUTE FOR INTEGRATIVE MEDICINE
at Northwestern
500 N. Michigan Ave., Suite 450
Chicago, IL 60611

Office Use Only

Date _____
Site _____
Physician _____

Please fill in the information below.

PATIENT REGISTRATION

Last Name _____ First Name _____ Middle Initial _____
Birth Date _____ SSN _____ Sex _____ Marital Status _____
Address _____ Apt _____
City _____ State _____ Zip _____
Cell Number _____ Home Number _____
Preferred Phone Number: Cell Home Work E-mail Address _____
Referred By _____ Primary Care Physician _____

DEMOGRAPHICS

Preferred Language: English Indian Russian Spanish Other _____
Race: American Indian Asian Native Hawaiian Black White Hispanic Other _____
Ethnicity: Hispanic Non-Hispanic Do not wish to answer

PATIENT EMPLOYEE INFORMATION

Employer _____ Occupation _____
Address _____
City _____ State _____ Zip _____ Work Phone _____

EMERGENCY CONTACT

Name _____ Relationship _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____
Group Name _____ Subscriber Number _____
Policy Holder Name _____ Relationship _____ Birth Date _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____
Group Name _____ Subscriber Number _____
Policy Holder Name _____ Relationship _____ Birth Date _____

PHARMACY INFORMATION

Local Pharmacy _____ Phone _____ Address _____
Mail Order Pharmacy (if applicable) _____ Phone _____ State _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMES PROVIDED FOR PROFESSIONAL SERVICES RENDERED

Signed: _____
Date: _____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM

Signed: _____
Date: _____