ADVANCED SURGICAL CARE OF NORTHERN ILLINOIS
PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address/City/State/Zip:	Social Security #	Home phone : ( ) Cell Phone: ( )

Email Address:			

Occupation:	Employer:	Employer phone no.: ( )

Who referred you to our office? (please check one box):	❑ Dr._____	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Primary Care Physician Name/Address:

Preferred Pharmacy Name and City:

Race (please check one box): ❑ Caucasian ❑ Asian ❑African-American ❑ Hispanic ❑ Hawaiian/Pacific Islander ❑Prefer not to answer
Ethnicity (please check one box) ❑ Hispanic ❑ Non-Hispanic

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance					

Subscriber's name:	Subscriber's Social Security#	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone: ( )	Cell Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician**. I understand that I am financially responsible for any balance**. I also authorize Advanced Surgical Care of Northern Illinois to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Advanced Surgical Care of Northern Illinois, Ltd.

_____ _____
Name *Date*

Health History Form

Your answer on this form will help your heath care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Thank You.

Date of Birth: _____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

_____

Current Height_____ Weight_____

Medical History

Have you ever had anesthesia? ☐ Yes ☐ No Did you experience any of the following:

☐ Airway problem? ☐ Malignant hypothermia (High fever during surgery?)

Do you smoke? ☐ Yes ☐ No How many packs per day?_____ How many years?_____

Do you consume alcohol? ☐ Yes ☐ No Quantity?_____ How often?_____

Does your medical history include any of the following:

☐ Asthma	☐ Bronchitis or chronic cough	☐ Anemia	☐ Hypertension
☐ Heart Attack	☐ Irregular Heart Beat	☐ Emphysema	☐ Stomach Ulcer
☐ Mitral Valve Prolapse	☐ Swelling in hands or feet	☐ High blood pressure	☐ Chest pain
☐ Diabetes	☐ Hepatitis or jaundice	☐ Heart Murmur or rheumatic fever	☐ Stroke
☐ Glaucoma	☐ Thyroid problem	☐ Epilepsy or seizures	☐ Kidney problem
☐ Joint stiffness or Arthritis	☐ Coagulation or bleeding problem	☐ Back pain or injury	

☐ Other _____

_____

MEDICATIONS: **SUGICAL HISTORY:**

Medication/Vitamin/Supplement	Dosage/Strength (e.g. mg/pill)	How many times daily?	Surgeries	Year of Surgery	Reason for Surgery
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
7			7		
8			8		
9			9		
10			10		

ALLERGIES: Do you have allergies or reactions to:

Medications	**Reaction**	**Foods**	**Reaction**
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Financial Policy
Advanced Surgical Care of Northern Illinois, Ltd

Thank you for choosing us as your healthcare provider. We are committed to your medical treatment and well-being and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Your Insurance Coverage

Advanced Surgical Care of Northern Illinois participates with many insurance company plans. We will file all charges incurred to your insurance company as a courtesy as long as we have accurate and complete insurance information; however, it is your responsibility to follow up on all claims with your insurance company to ensure payment. The entire balance due is yours responsibility if we have not received payment from your insurance company within 45 days from the date of service. If your insurance company denies payment for any reason, you will be financially responsible for the entire balance. Please note that your health insurance policy is an agreement between yourself and your insurance company and it is your responsibility to understand and be familiar with the terms of that agreement. Our staff will be happy to assist you in obtaining the specific terms of your health insurance policy upon request.

Co-payments are due at the time service unless other arrangements have been made in advance. This includes applicable coinsurance and copayments. We accept cash, personal checks, VISA, and MasterCard. There is a service charge of $35.00 for returned checks.

For all services rendered to minor patients, we will look to the adult accompanying the patient, authorizing treatment and the parent or guardian with custody for payment.

Missed Appointments/Late Cancellations

Your appointment time is reserved especially for you. Please call to cancel your appointment at least 24 hours prior to your scheduled appointment if you will be unable to keep your appointment. This allows the practice to offer that time to another patient. If you fail to show up for your appointment or do not cancel 24 hours prior to your scheduled appointment, there may be a $50.00 fee charged to your account. Patients who repeatedly schedule and fail to keep their appointments or have late cancellations may be discharged from the practice.

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I have read and understand Advanced Surgical Care of Northern Illinois' Policy. I agree to assign insurance benefits to Advanced Surgical Care and agree to release any medical or other information necessary in order to process insurance claims.

Please Print the Name of the Patient:_____

Signature of Patient or Responsible Party if a minor:_____

Date: _____