Advanced SURGICAL CARE of Northern Illinois, LTD.

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

◦ MR. ◦ MRS. ◦ MISS. ◦ MS. PATIENT'S LAST NAME	FIRST	MIDDLE	◦ MARITAL STATUS ◦ SINGLE ◦ MARRIED ◦ DIVORCED ◦ SEPARATED ◦ WIDOW	
IS THIS YOUR LEGAL NAME? ◦ YES ◦ NO IF NOT, WHAT IS YOUR LEGAL NAME (FORMER NAME)?			BIRTH DATE / /	AGE SEX p M p F
STREET ADDRESS:	SOCIAL SECURITY # (Last 4) 000-00-		HOME PHONE ( )	
CITY / STATE / ZIP:	EMAIL:		CELL PHONE ( )	
OCCUPATION:	EMPLOYER:		WORK PHONE ( )	

WHO REFERRED YOU TO OUR OFFICE (PLEASE CHECK ONE)? ◦ FAMILY ◦ FRIEND ◦ CLOSE TO HOME / WORK ◦ INTERNET
◦ DR._____ ◦ INSURANCE PLAN ◦ HOSPITAL ◦ 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

INSURANCE COMPANY #1	INSURED'S NAME	INSURED'S BIRTH DATE / /
INSURANCE COMPANY #2	INSURED'S NAME	INSURED'S BIRTH DATE / /

PERSON RESPONSIBLE FOR THE BILL:

IN CASE OF

NAME:	HOME PHONE ( )
RELATIONSHIP TO PATIENT:	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

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_____ _____
Name *Date*

Your answer on this form will help your health 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: _____

Current Height_____ Weight_____ Other concerns:

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 ◦ Anemia ◦ Hypertension/High Blood Pressure
◦ Heart Attack ◦ Irregular Heart Beat ◦ Emphysema ◦ Stomach Ulcer
◦ Mitral Valve Prolapse ◦ Swelling in hands or feet ◦ Chest pain ◦ Joint stiffness or Arthritis
◦ Diabetes ◦ Hepatitis or jaundice ◦ Kidney problem ◦ Back pain or injury
◦ Thyroid problem ◦ Epilepsy or seizures ◦ Heart Pacemaker (please have card available) ◦
◦ Tuberculosis ◦ Stroke ◦ Cancer (type)
◦ Other

MEDICATIONS:

Medication/Vitamin/Supplement	Dosage/Strength (e.g. mg/pill)	How many times Daily?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

FAMILY HISTORY	**MOTHER**	**FATHER**	**OTHER**
Cancer (please specify)	◦	◦	◦
Heart Disease	◦	◦	◦
Diabetes	◦	◦	◦
Stroke	◦	◦	◦
Hypertension	◦	◦	◦
Other	◦	◦	◦

ALLERGIES: Do you have allergies or reactions to:

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

FINANCIAL AND PRIVACY POLICIES
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. We are also committed to protecting your personal health information as detailed in our policy "Medical Information Rights and Responsibilities".

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, including, but not limited to any co-pays, deductibles or co-insurance amounts that are your responsibility. 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 $50.00 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.

Your Medical Information: Your rights - Our responsibilities

Your privacy is important to us. Please inform the staff if you need another copy or did not receive our privacy policy.

I have read and understand Advanced Surgical Care of Northern Illinois' Financial and Privacy policies. 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: _____

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CONSENT FOR RELEASE OF HEALTH INFORMATION

Patient name: _____

Date of Birth: _____

Please specify if we can leave you a detailed message:	Leave Detailed Message Yes No	Leave Detailed Lab/Test Results Yes No

*Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include **sensitive health information (SHI)** such as mental health, developmental disabilities, AIDS/HIV, Drug/Alcohol treatment and or Genetic testing.

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Advanced Surgical Care locations and Physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Name	Relationship	Release SHI? (circle one)
		Yes No
		Yes No
		Yes No
		Yes No

Please Print Name of Patient: _____

Signature of Patient or Responsible Party if a minor:_____

Date: _____