REGISTRATION FORM

Today's date:	Clinic: ❑ Lombard ❑ Glendale Heights	PCP:

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:	Social Security no.:	Home phone no.: ( )
City:	State:	ZIP Code:	E-Mail:
Occupation:	Employer:	Employer phone no.: ( )

Ethnicity: ❑ Non-Hispanic ❑ Hispanic ❑ Not Specified	Preferred Language:	Race:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

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

Is this person a patient here? ❑ Yes ❑ No

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

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ Blue Cross	❑ United Health	❑ Cigna
❑ Humana	❑ Aetna	❑ Great West	❑ TriCare	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	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 of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Primary Care Services, S.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of my insurance benefits to Primary Care Services, SC for services rendered to my dependents or me. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Primary Care Services, SC is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Primary Care Services, SC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I certify that I have received and read a copy of the Primary Care Services, SC Patient Information Privacy Policy. I hereby authorize Primary Care Services, SC or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Primary Care Services, SC or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Primary Care Services, SC to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing, and treatment as directed by Primary Care Services, SC and or their designee.

PATIENT SIGNATURE:____ Date:______________

GUARANTOR SIGNATURE:____ Date:______________

GUARANTOR NAME:____ Date:______________

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I.):*		❑ M ❑ F	**DOB:**
Marital status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed			
Previous or referring doctor:	**Date of last physical exam:**		
Describe briefly your present symptoms:			
When did your symptoms start:			

PAST MEDICAL HISTORY

Childhood illness: ❑ Measles ❑ Mumps ❑ Rubella ❑ Chickenpox ❑ Rheumatic Fever ❑ Polio

Do you now or have you ever had: (check if "YES")

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other significant illness (please list):

Previous hospitalizations/Surgeries

Year	Reason	Hospital

Any other serious injuries?	❑ No ❑ Yes	If Yes, please describe:

Have you ever had a blood transfusion?	❑ Yes	❑ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies		
Drug	❑ No ❑ Yes	If Yes, please explain reaction you had:
Food/environmental	❑ No ❑ Yes	If Yes, please explain reaction you had:
Allergic to any of the following:	❑ Latex ❑ Tape ❑ Shellfish/Seafood ❑ Iodine contrast/dye	

SOCIAL HISTORY AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL					
Education	❑ High School/GED	❑ Some College	❑ Degree (Associates)		
	❑ 4-Year College Degree (BA, BS)	❑ Master's Degree	❑ Professional (MD, JD)		
Employment	Occupation:	Employer:			
Exercise	❑ Sedentary (No exercise)				
	❑ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	❑ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	❑ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			❑ Yes	❑ No
	If yes, are you on a physician prescribed medical diet?			❑ Yes	❑ No
	Rank salt intake	❑ Hi	❑ Med	❑ Low	
	Rank fat intake	❑ Hi	❑ Med	❑ Low	
Caffeine	❑ None	❑ Coffee	❑ Tea	❑ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			❑ Yes	❑ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			❑ Yes	❑ No
	Have you considered stopping?			❑ Yes	❑ No
	Have you ever experienced blackouts?			❑ Yes	❑ No
	Are you prone to "binge" drinking?			❑ Yes	❑ No
	Do you drive after drinking?			❑ Yes	❑ No
Tobacco	Do you use tobacco?			❑ Yes	❑ No
	❑ Cigarettes – pks./day	❑ Chew - #/day	❑ Pipe - #/day	❑ Cigars - #/day	
	❑ # of years	❑ Or year quit			

Drugs	Do you currently use recreational or street drugs?	❑ Yes	❑ No
	Have you ever given yourself street drugs with a needle?	❑ Yes	❑ No
Personal Safety	Do you live alone?	❑ Yes	❑ No
	Do you have frequent falls?	❑ Yes	❑ No
	Do you have any special communication needs?	❑ Yes	❑ No
	Do you have visual impairment?	❑ Left Eye	❑ Right Eye
	Do you have hearing impairment?	❑ Left Ear	❑ Right Ear
	Do you have an Advance Directive or Living will?	❑ Yes	❑ No
	Do you have Power of Attorney?	❑ Yes	❑ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	❑ M ❑ F	
Mother				❑ M ❑ F	
Sibling	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F		**Grandmother** *Maternal*		
	❑ M ❑ F		**Grandfather** *Maternal*		
	❑ M ❑ F		**Grandmother** *Paternal*		
	❑ M ❑ F		**Grandfather** *Paternal*		
	History of substance abuse: ❑ No ❑ Yes			History of mental health: ❑ No ❑ Yes	

MENTAL HEALTH

Is stress a major problem for you?	❑ Yes	❑ No
Do you feel depressed?	❑ Yes	❑ No
Do you panic when stressed?	❑ Yes	❑ No
Do you have problems with eating or your appetite?	❑ Yes	❑ No
Do you cry frequently?	❑ Yes	❑ No
Have you ever attempted suicide?	❑ Yes	❑ No
Have you ever seriously thought about hurting yourself?	❑ Yes	❑ No
Do you have trouble sleeping?	❑ Yes	❑ No
Have you ever been to a counselor?	❑ Yes	❑ No

WOMEN ONLY

Age at onset of menstruation:					
Date of last menstruation:					
Period every _____ days					
Heavy periods, irregularity, spotting, pain, or discharge?				❑ Yes	❑ No
Number of pregnancies _____ Number of live births _____					
Are you pregnant or breastfeeding?				❑ Yes	❑ No
Have you had a D&C, hysterectomy, or Cesarean?				❑ Yes	❑ No
Any urinary tract, bladder, or kidney infections within the last year?				❑ Yes	❑ No
Any blood in your urine?				❑ Yes	❑ No
Any problems with control of urination?				❑ Yes	❑ No
Any hot flashes or sweating at night?				❑ Yes	❑ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?				❑ Yes	❑ No
Experienced any recent breast tenderness, lumps, or nipple discharge?				❑ Yes	❑ No
Date of last pap and rectal exam?	Pap:	______ / ______ /______	Rectal:	______ / ______ /______	

MEN ONLY

Do you usually get up to urinate during the night?				❑ Yes	❑ No
If yes, # of times _____					
Do you feel pain or burning with urination?				❑ Yes	❑ No
Any blood in your urine?				❑ Yes	❑ No
Do you feel burning discharge from penis?				❑ Yes	❑ No
Has the force of your urination decreased?				❑ Yes	❑ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?				❑ Yes	❑ No
Do you have any problems emptying your bladder completely?				❑ Yes	❑ No
Any testicle pain or swelling?				❑ Yes	❑ No
Date of last prostate and rectal exam?	Prostate:	______ / ______ /______	Rectal:	______ / ______ /______	

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

HEALTH CARE MAINTENANCE CHART

TESTS	YEAR DONE	NEXT DUE	REFUSED	N/A
• PPD (Tuberculosis skin test)				
VACCINATIONS				
• Hepatitis A				
• Hepatitis B				
• HPV				
• Influenza				
• H1N1				
• Pneumococcal				
• Td/Tdap				
• MMR*				
• Varicella*/Zoster*				
CANCER SCREENING				
• Cervical (Pap smear)				
• Mammogram				
• PSA				
• Colonoscopy/Sigmoidoscopy				
• Fecal occult blood test				
• Skin				
SCREENING OTHER				
• Blood pressure				
• Ophthalmologic				
• Osteoporosis (DXA scan)				
LABORATORY EXAM				
• Complete blood cell count				
• Liver function tests				
• Creatinine				
• B12/folate/iron				
• 25 OH vitamin D				
• Hb A1c Level				
• Lipids/Fasting				
• Glucose				
• Other				
GENERAL - COUNSELING				
• Smoking cessation				
• Alcohol cessation				
• Safe sex				

Primary Care Services, S.C.
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Lombard, IL 60148-5363

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Fax:(630) 429-9060

my-primarycare.com

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

SECTION: 1 - Patient Information (please print and complete ALL blanks)	
First Name: ______________________________	Last Name:______________________________
Previous Name: ___________________________	Phone #:________________________________
Date of Birth: ____________________________	Social Security #: ________________________
Address: ________________________________	City/State/ZIP: ___________________________

SECTION 2: Information Requested (please check all appropriate boxes)

☐ Healthcare information relating to the following treatment, condition, or dates:
____

☐ All healthcare information - All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ SPECIFIC Department/Physician/Clinic Location:_______________________________________

☐ Radiology Reports	☐ Radiology Images	☐ Cardiac Testing
☐ Labs	☐ Medication List	☐ Immunizations
☐ Physical Therapy	☐ Progress Notes	☐ Other: _________________

Sensitive Records

☐ Mental Health	☐ HIV/AIDS/STD	☐ Genetic Testing	☐ Drug/Alcohol Abuse

Witness signature is required for the release of these sensitive record types; for a minor aged **12-17** the minor's signature is required for the release of Mental Health, HIV/AIDS/STD or Drug/Alcohol Abuse records.

Initials: ___________________________

SECTION 3: I authorize Primary Care Services to release the above patient records to:	
Name of Individual/Organization:____	
Phone: ________________________________	Fax: ___________________________________
Address: _______________________________	City: __________________________________
State: _________________________________	ZIP: ___________________________________
SECTION 4: Method of Delivery	
☐ Fax #: ______________________________	☐ US Mail
☐ Call for pick up by patient or legal representative (pickup in ☐ Lombard or ☐ Glendale Heights – select one). A photo ID is required for pick up.	
SECTION 5: Purpose of Disclosure (records are subject to charges)	
☐ Continuation of Care	☐ Personal Reasons	☐ Insurance
☐ Legal	☐ Other:______________________________
SECTION 6: Signatures	

- I understand, I have the right to revoke this authorization in writing at any time by sending revocation to Primary Care Services, (PCS) at the address listed above. The revocation will not apply if PCS has already taken action in reliance on the authorization.
- I understand, I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- I understand, that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand, I have the right to refuse to sign this authorization and PCS does not condition treatment on this authorization, except disclosure necessary for payment of claims or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).
- I understand, this authorization will expire in **90** days or upon the following specified date or event.

I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature:_______________________________________ **Date:** __________________	
Representative Signature (for minor, etc.): ____	
Relationship:____________________________	**Date:**___________________________________
Witness Signature:*_____________________	**Date:**___________________________________
*Witness signature required for any sensitive records to be released if so selected in Section 2	