



REGISTRATION FORM

Today's date:		Clinic: <input type="checkbox"/> Lombard <input type="checkbox"/> Glendale Heights		PCP:		
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:	Home phone no.: ()		
City:	State:	ZIP Code:		E-Mail:		
Occupation:	Employer:			Employer phone no.: ()		
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:		Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> United Health	<input type="checkbox"/> Cigna
<input type="checkbox"/> Humana	<input type="checkbox"/> Aetna	<input type="checkbox"/> Great West		<input type="checkbox"/> TriCare	<input type="checkbox"/> Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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.: ()
<p>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.</p>				
<hr/> <i>Patient/Guardian signature</i>			<hr/> <i>Date</i>	



DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of my insurance benefits to Primary Care Services, SC (PCS) 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.

24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, PCS reserves the right to charge a fee of \$25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

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, TEXT 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, text 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 <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio			
Do you now or have you ever had: (check if "YES")			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Heart murmur <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS </td> </tr> </table>	<input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS	
Other significant illness (please list):			

Previous hospitalizations/Surgeries		
Year	Reason	Hospital
Any other serious injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please describe:		

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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	<input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, please explain reaction you had:
Food/environmental	<input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, please explain reaction you had:
Allergic to any of the following: <input type="checkbox"/> Latex <input type="checkbox"/> Tape <input type="checkbox"/> Shellfish/Seafood <input type="checkbox"/> Iodine contrast/dye		

SOCIAL HISTORY AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

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

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

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS	
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother				<input type="checkbox"/> M <input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>			
	History of substance abuse: <input type="checkbox"/> No <input type="checkbox"/> Yes			History of mental health: <input type="checkbox"/> No <input type="checkbox"/> Yes		

MENTAL HEALTH

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

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?

OTHER PROBLEMS

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

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> 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.
 2500 S. Highland Ave., Suite 230,
 Lombard, IL 60148-7103

Phone: (630) 429-9000
 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)			
<input type="checkbox"/> Healthcare information relating to the following treatment, condition, or dates: _____			
<input type="checkbox"/> 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.			
<input type="checkbox"/> SPECIFIC Department/Physician/Clinic Location: _____			
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Cardiac Testing	
<input type="checkbox"/> Labs	<input type="checkbox"/> Medication List	<input type="checkbox"/> Immunizations	
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Other: _____	
Sensitive Records			
<input type="checkbox"/> Mental Health	<input type="checkbox"/> HIV/AIDS/STD	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> 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/receive the above patient records to/from:

Name of Individual/Organization: _____	
Phone: _____	Fax: _____
Address: _____	City: _____
State: _____	ZIP: _____

SECTION 4: Method of Delivery

<input type="checkbox"/> Fax #: _____	<input type="checkbox"/> US Mail
<input type="checkbox"/> Call for pick up by patient or legal representative (pickup in <input type="checkbox"/> Lombard or <input type="checkbox"/> Glendale Heights – select one). A photo ID is required for pick up.	

SECTION 5: Purpose of Disclosure (records are subject to charges)

<input type="checkbox"/> Continuation of Care	<input type="checkbox"/> Personal Reasons	<input type="checkbox"/> Insurance
<input type="checkbox"/> Legal	<input type="checkbox"/> 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