

NORTHWEST SUBURBAN MEDICAL GROUP

Patient's Name: _____ Date of Birth: _____ Male Female
 Social Security #: _____ Marital Status: Single Married Divorced Widowed
 Home Address: _____ Apt #: _____
 City: _____ State: _____ Zip: _____ Email: _____
 Home # _____ Cell Phone: _____ Ethnicity: Latino Non-Latino
 Race: Asian African American American Indian Native Hawaiian Pacific Islander White Unreported
 Emergency Contact: _____ Relationship: _____
 Emergency Contact Phone #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____
 ID #: _____ Group #: _____
Secondary Insurance Company: _____
 ID #: _____ Group #: _____

POLICY HOLDER IF DIFFERENT FROM PATIENT

Policy Holders Name: _____ Date of Birth: _____ Male Female
 SS#: _____ Phone #: _____ Relationship to Patient: _____

SOCIAL HISTORY

Recreational Drug Use? Yes No Type: _____
 Tobacco Use? Yes No Type: _____ How many per day: _____ Packs/cigarettes (circle one)
 # of years using? _____ Last used: _____
 Alcohol Use? Yes No Socially # of drinks _____ (check one) per day Per week Per month
 Caffeine Use? Yes No Type: _____ # cups per day _____

SURGICAL HISTORY: *(If applicable, please check the box and enter the year)*

| Condition | Year | Condition | Year | Condition | Year | Other: | |
|--|------|--|------|---|------|--------|--|
| <input type="checkbox"/> Eyes (laser/glaucoma/cataracts) | | <input type="checkbox"/> Stomach/intestine/colon | | <input type="checkbox"/> Shoulder/feet/hands | | | |
| <input type="checkbox"/> Ears | | <input type="checkbox"/> Varicose Veins | | <input type="checkbox"/> Spine/Back/Neck | | | |
| <input type="checkbox"/> Sinus/Nasal Septum | | <input type="checkbox"/> Tubal Ligation | | <input type="checkbox"/> Hips / Knees | | | |
| <input type="checkbox"/> Tonsil/Adenoids | | <input type="checkbox"/> Hemorrhoids | | <input type="checkbox"/> Prostate / Vasectomy | | | |
| <input type="checkbox"/> Thyroid | | <input type="checkbox"/> Hernia | | <input type="checkbox"/> Uterus/Hysterectomy | | | |
| <input type="checkbox"/> Heart | | <input type="checkbox"/> Gallbladder | | <input type="checkbox"/> C-section | | | |

PAST MEDICAL HISTORY *(If applicable to YOU, please check the box)*

| | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Skin Disease/Sores |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Anxiety Problem | <input type="checkbox"/> Ear/Hearing Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach/Digestive Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Eye/Vision Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Tuberculosis or +TB Test |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gallbladder Stones/Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Urinary Problem |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Gastritis/Ulcer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Crohn's Diseases |
| <input type="checkbox"/> Bone/joint Injuries | <input type="checkbox"/> Gout | <input type="checkbox"/> Menstrual Problems | Other: |
| <input type="checkbox"/> Cancer, type? | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Heart Rhythm Problem | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Dementia/Memory Loss | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Prostate Disorder | |
| <input type="checkbox"/> Dental/ Oral Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexually transmitted Disease | |

Drug Allergies? Yes No List: _____ Reaction: _____

Current Medications: Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

| Name of Drug and Dose (strength) | Directions of Medication (how many daily) |
|----------------------------------|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

FAMILY HISTORY:

| Condition | Relationship | Condition | Relationship | Other (list relationship): |
|---|--------------|---|--------------|----------------------------|
| <input type="checkbox"/> Cancer/type | | <input type="checkbox"/> Rheumatoid Arthritis | | |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Thyroid Issues | | |
| <input type="checkbox"/> Congestive Heart Failure | | <input type="checkbox"/> Osteoporosis | | |
| <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> Asthma/ COPD | | |
| <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Alzheimer's Disease | | |
| <input type="checkbox"/> High Cholesterol | | <input type="checkbox"/> Alcoholism | | |
| <input type="checkbox"/> Stroke | | <input type="checkbox"/> Seizures | | |
| <input type="checkbox"/> Kidney Disease | | <input type="checkbox"/> Migraines | | |
| <input type="checkbox"/> Chronic Lung Disease | | <input type="checkbox"/> Depression | | |

| Family Member | Alive or Deceased | Age at Death | Cause Of Death |
|---------------|-------------------|--------------|----------------|
| Mother | | | |
| Father | | | |
| Siblings | | | |
| Children | | | |

Patient Name: _____ Date of Birth: _____

Patient Financial Agreement and Acknowledge of Privacy Practice

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. **Initials:** _____
- **Deductible Payments:** if your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A \$100.00 payment will be due at the time of service. Please note the \$100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice. **Initials:** _____
- **Claims Submission:** we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Initials:** _____
- **Preventative Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible, or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services. **Initials:** _____
- **Cash Pay Patients:** the amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but are not limited to, laboratory tests, x-ray tests, any injections, special procedures, or additional office visit charges. **Initials:** _____
- **Laboratory Bills:** any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact the laboratory directly for any questions regarding your lab bill. **Initials:** _____
 - **Missed Appointments/ No Shows:** Please note a \$25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time, these charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. **Initials:** _____

*If at any time you should experience hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer-sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am a guarantor for. **Initials:** _____

Acknowledgment of Receipt of Notice of Privacy Practices: I hereby acknowledge that I have been offered a copy of Northwest Suburban Medical Group's Notice of Privacy Practices. I have been advised that a copy of the current notice will be posted in the reception area and that any amended Notice of Privacy Practices will be available at each appointment. **Initials:** _____

CONSENT FOR TREATMENT: I hereby authorize the physicians, mid-level providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable. **Initials:** _____

I have read and understood the above statements. I agree to comply with the financial policies of the office, and I am financially responsible for my account. I have read and understood the Assignment of Benefits and Acknowledgement of Receipt of Notice of Privacy Practices. I have read and give consent for treatment.

I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the service have been answered to my satisfaction

Signature of Patient /Guardian if Minor (Relationship of the patient if minor) _____
Date

HIPAA Acknowledgement and Communication Form

I acknowledge that I received a Northwest Suburban Medical Group S.C, Notice of Privacy Practices. We routinely call patients for the following reasons: Schedule appointments, appointment reminders, test results, and when replying to your questions and/or concerns.

If we attempt to contact you and you are not available:

| | Yes | No |
|---------------------------------------|-----|----|
| Leave information on voicemail | | |
| Leave information with family members | | |

I grant Northwest Suburban Medical Group S.C. permission to discuss my care with the following:

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number