LAKE COUNTY MEDICAL GROUP
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GRAYSLAKE, IL 60030

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REGISTRATION FORM

DATE _____

LAST NAME_____ FIRST NAME_____MI_____

ADDRESS_____CITY_____STATE____ZIP_____

BIRTH DATE_____SS#_____GENDER_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

HIGHEST LEVEL OF EDUCATION_____

E-MAIL_____MARITAL STATUS_____

SEXUAL ORIENTATION (circle) Heterosexual-straight Bisexual Lesbian/Gay

Ethnicity: (circle one) Hispanic or Latin, Not Hispanic or Latin, Refuse to Report

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Other Pacific Islander ☐ Unreported/Refuse to Report

PATIENT'S EMPLOYER_____CITY/STATE_____

OCCUPATION_____MAY WE CALL YOU AT WORK_____

SPOUSE'S NAME_____BIRTH DATE_____

SPOUSE'S EMPLOYER/OCCUPATION_____

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU FOR EMERGENCY CONTACT:

_____

RELATIONSHIP_____PHONE NUMBER_____

WHOME MAY WE THANK FOR REFERRING TO US_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE THIS PHYSICIANS OFFICE TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY ILLNESSES/TREATMENTS AND I HEREBY ASSIGN TO THIS PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

PATIENT SIGNATURE_____DATE_____

INSURED SIGNATURE_____DATE_____

A PHOTOCOPY OF THIS AUTHORIZATION AND ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENTS NAME_____ DOB_____ TODAYS DATE_____

PATIENT'S MEDICAL HISTORY PAGE 2

FAMILY HISTORY: (IMMEDIATE FATHER, MOTHER, BROTHERS, SISTERS, GRANDPARENTS)

ALIVE? AGE MEDICAL PROBLEMS OR CAUSE OF DEATH

FATHER_____

MOTHER_____

OTHER_____

OTHER_____

PLEASE SPECIFY IF YOU HAD ANY OF THE FOLLOWING:

DATE AND REULTS

CHEST X-RAY_____

BONE DENSITY_____

EKG_____

COLONOSCOPY_____

ENDOSCOPY_____

EYE EXAM_____

PROSTATE EXAMINATION/PSA_____

CHOLESTEROL_____

BLOOD SUGAR OR A1C_____

FLU VACCINE_____ PNEUMONIA VACCINE_____ TETANUS VACCINE_____ SHINGLES VACCINE_____

FOR WOMEN ONLY:

LAST PAP SMEAR_____ RESULTS_____

LAST MAMMOGRAM_____ RESULTS_____

DO YOU USE BIRTH CONTROL?_____ IF YES, LIST KIND_____

DO YOU TQAKE HORMONE SUPPLEMENTS_____ IF YES, LIST KIND_____

NUMBER OF PREGNANCIES_____ NUMBER OF MISSCARRIAGES_____

PATIENTS NAME_____ DOB_____ TODAYS DATE_____

PATIENT'S MEDICAL HISTORY

PLEASE LIST ANY OTHER PHYSICIANS YOU CURRENTLY SEE:

_____

_____

LIST ALL MEDICATIONS YOU TAKE (PRESCRIPTION AND NON-PRESCRIPTION) OR YOU MAY PROVIDE US WITH A LIST: (PLEASE INCLUDE DOSAGE AND FREQUENCY)

_____ _____ _____

_____ _____ _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING OR LIST ALLERGIES?

__ASPIRIN __PENICILLIN __CODEINE __LATEX __ANESHETICS __ERYTHROMYCIN __SULFA

OTHER ALLERGIES:_____

ARE YOU A CURRENT SMOKER?_____ IF YOU SMOKE, HOW MANY PACKS A DAY?_____

ARE YOU A FORMER SMOKER?__ IF SO, WHEN DID YOU QUIT?__HOW MANY YEARS DID YOU SMOKE?__

DO YOU DRINK ALCOHOL?____ IF YOU DO DRINK ALCOHOL, HOW MANY DRINKS A WEEK?_____

DO YOU USE ILLICIT(RECREATIONAL) DRUGS?____ IF SO, WHAT KIND?_____

DO YOU EXERCISE REGULARLY?_____

HAVE YOU EVER BEEN IN THE HOSPITAL OR HAD SURGERY? _____ IF YES, FOR WHAT AND WHEN?

_____

_____

_____

MEDICAL HISTORY: PLEASE CIRCLE ALL PAST AND PRESENT MEDICAL PROBLEMS/SYMPTOMS:

AIDS/HIV POSITIVE	DIZZINESS	HIGH BLOOD PRESSURE	CONSTIPATION	TUBERCULOSIS
ALCOHOLISM	EXCESSIVE URINATION	KIDNEY DISEASE	SHINGLES/HERPES	ULCERS
ANEMIA	FATIGUE	PROSTATE DISEASE	SHORTNESS OF BREATH	SEIZURES
ANGINA	FIBROIDS	URINARY INCONTINENCE	DRUG/SUBSTANCE ABUSE	
ARTHRITIS	GOUT	DIFFICULTY URINATING	THYROID DISEASE	
ASTHMA	HEARING LOSS	LIVER DISEASE	PSYCHIATRIC PROBLEMS	
BACK PAIN	HEART ATTACK	LEG CRAMPS	GASTROINTESTINAL BLEEDING	
CANCER	HEART DISEASE	LUNG DISEASE	CHRONIC HEADACHES	
DEPRESSION	HEART MURMUR	PALPATATIONS	HIGH BLOOD PRESSURE	
DIABETES	HEPATITIS	RHEUMATIC FEVER	STROKE	

LAST NAME_____ FIRST NAME_____

FINANCIAL POLICY

Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS YOU PROVIDE TO US AN APPROVED INSURANCE COMPANY. WE ACCEPT CASH OR CREDIT CARD ONLY ON YOUR FIRST VISIT TO OUR OFFICE. CHECKS WILL ONLY BE ACCEPTED AFTER YOUR FIRST VISIT.

ANY RETURNED CHECK WILL INCUR A $30.00 SERVICE CHARGE.

REGARDING INSURANCE:

We may accept assignment of insurance benefits, however we require that all co-payments/or if you are self-paying the entire bill be paid in full at time of service/or if you have a large deductible payment of 20% of your bill is required. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you provide us with the correct information. Your insurance policy is a contract between you and you insurance company, we are not party to that contract. If your insurance company has not paid your account in full within 60 days, the full balance will be your responsibility. Please be aware that some, perhaps all, of the services provided to you by Lake County Medical Group may be non-covered services and not-considered reasonable and necessary under certain medical insurance policies.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for your patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

An adult parent or guardian must accompany all minor patients. For any unaccompanied minor, non-emergency treatment will be denied. The parents/guardians are responsible for providing insurance information to us.

MISSED APPOINTMENTS:

Unless cancelled, at least 24 hours in advance or arranged with our office staff, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS. Please help us to serve you better by keeping scheduled appointments. Thank you for your understanding of our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY.

X_____ DATE:_____

VERY IMPORTANT: PLEASE <u>DO NOT BRING CHILDREN</u> TO YOUR OFFICE APPOINTMENTS. THIS ALLOWS YOUR DOCTOR TO DEDICATE THEIR FULL ATTENTION TO YOU. IF YOU CANNOT ARRANGE CHILDCARE PLEASE CALL OUR OFFICE TO RESCHEDULE YOUR APPOINTMENT. THANK YOU FOR YOUR UNDERSTANDING.