Registration Information

Last Name:_____ First Name: _____

Street Address: _____ Phone#: _____

City: _____ State: _____ Zip Code: _____

Cell_____Email_____

Sex (M/F): _____ Marital Status: _____Date of Birth _____

Social Security Number _____Referred by: _____

Employer/Company: _____Occupation: _____

City: _____ Phone: _____ Zip Code: _____

Spouse

Name: _____Phone # _____

Address: _____City: _____State: _____Zip Code: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Preferred Pharmacy

Pharmacy Name: _____ City: _____Phone: _____

Assignment and Release of Medical Information

In consideration of medical treatment to be received, I do hereby assign, transfer and set over to my physician, all my rights, title and interest in the health insurance policy or policies that I have listed on my patient registration form to the extent of benefits available. I understand that I am financially responsible for the changes not covered by this authorization.

I authorize the release of my medical records including histories and physicals, doctors orders, notes and reports and nurses notes to my medical insurers and to any insurance companies against whom I have a right claim or cause of action.

Signed: _____ Date: _____

[redacted] FAMILY AND PERSONAL HEALTH HISTORY [redacted]

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name _____ Age _____ Birthdate _____ Today's Date _____

Occupation _____ Last Physical Examination Date _____ Daytime Phone _____

Family Record Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism								
Allergies								
Asthma								
Thyroid Problems								
Cancer, Tumor, type								
Colitis (Ulcerative/Chron's)								
Diabetes (pills or Insulin)								
Emphysema								
Epilepsy								
Glaucoma								
Goiter								
Hay Fever								
Heart Attack								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Mental Illness								
Migraine								
Obesity								
Rheumatic Fever								
Sickle-Cell Anemia								
Stroke								
Tuberculosis								

Family Members

Living					**Deceased**		
	AGE	Health ✓ Good	✓ Fair	✓ Poor	DEATH AGE	Cause of Death
Father						
Mother						
Brother(s)						
Sister(s)						
Children						

Patient Record Operations	✓ Yes	✓ No	Date
Tonsils			
Appendix			
Stomach			
Colon			
Thyroid			
Hernia			
Breast (women)			
Uterus (women)			
Ovaries (women)			
Prostate (men)			
Biopsies/location			
Other - If yes, what:			
Do you: If yes, daily consumption			
Smoke Pkgs.			
Drink Coffee/Cola Cups			
Beer Ozs			
Hard Liquor/Wine			
Drugs (Marijuana, Etc.)			
Immunizations			
Pneumonia Vaccine			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Hepatitis, A,B,C			
Other - If yes, What:			
X-rays			
When was last mammogram?			
Back			
Chest			
Colon			
Head			
Gall Bladder			
Kidney			
Stomach			
TX-Radiation (Where)			
Other - If yes, what:			
Doctor's Use Only-Summary			

PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Asthma				
Abnormal Electrocardiogram				
Angina (Heart Pain)				
Anemia (Type)				
Arthritis -Hand, Knee, Hip, Back				
Broken Bones (Which)				
Cancer or Tumor (Where)				
Chronic Lung Disease/Emphysema				
Cirrhosis				
Colon or Bowel Trouble				
Deafness				
Depression/Anxiety/Panic Attacks				
Diabetes				
Gall Stones				
Glaucoma				
Goiter				
Gonorrhea/Syphillis/Herpes/Chlamydia				
Gout				
Hay Fever				
Heart Attack				
Heart Murmur as Adult				
Heartburn/Reflux				
High Blood Pressure				
Hepatitis (A,B,C,)				
HIV (aids) Tested				
Injury of Back or Neck				
Kidney Stones/Kidney Infection				
Migraine				
Phlebitis/ Blood Clots				
Rheumatic Fever				
Rectal Trouble/Hemorrhoids				
Recurrent Boils				
Seizures				
Skin Disease				

Doctor's Use Only

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Snoring				
Stomach or Duodenal Ulcer				
Stroke				
Thyroid (Overactive)				
Thyroid (Underactive)				
Tuberculosis				
Varicose Veins				
Men				
Prostate Problems				
Women				
Endometriosis				
Bladder Infection				
Mastitis				
Ovarian Cyst				
Breast Cysts/Fibromas				
Other Gynecological Problems*				
*Explain:				

Age Periods Stated _____
Age Periods Stopped _____
Why Periods Stopped _____
Number of Pregnancies _____
Number of Children _____
Number of Miscarriages _____
When was last Pelvic (pap) Exam

Hospitalization/Reasons

Do you wear artificial devices? yes___ no ____
Please list:

Do you have allergies (Med's) yes___ no ____
Please List:

Medications: (Please list):

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required

To provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

_____

I acknowledge that I have received a copy of this offices Notice of Privacy Practices.

_____

Please print your name here

_____ _____

Signature Date

I authorize Dupage Internal Medicine of IL, LLC to release all medical information including any and all test results and records which may contain drug abuse and/or alcoholism, HIV/AIDS or psychiatric/psychological information to:

_____

Name Relationship

_____ _____

Signature Date

If we are unable to reach you, may we leave normal test results on your answering service?

Please Initial YES _____ NO _____

For office use only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but could not be obtained because:

___ The patient refused to sign ___ We weren't able to communicate with the patient.

___ Due to emergency situation it was not possible to obtain acknowledgement.

___ Other (Please specify details) _____

_____ _____

Employee Name Date

DuPage Internal Medicine of Illinois, LLC

Prabhu Shivalingappa, M.D., Board Certified
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Financial Policy
Effective January 1st, 2018

Thank you for choosing Dupage Internal Medicine of IL for your healthcare needs. We are happy to serve you and look forward to a long-term relationship with you.

To serve you efficiently, we have instituted the following financial policy. This policy below outlines the understanding between you, the patient and our office. Our office will file insurance claims based upon the information you have provided us. It is your responsibility to provide us with complete and accurate information. You will be asked to provide this information on an annual basis. Failure to provide information necessary and required by your insurance company will result in denial of your claim. Insured parties are expected to know their plan requirements and abide by any specifications of their insurance plan. Furthermore, if your insurance company requests information from you, you must provide that information promptly. If your claim is denied, it becomes your responsibility to pay the balance in full. By signing below, you understand that you will be responsible for payment of any services not paid by your insurance company which includes co-payments, deductibles, coinsurance and non-covered items. We will send you a reminder statement when there is a balance to be paid by you. Any balances over 90 days or greater than $200 may be subject to a payment plan. In instances where it is deemed necessary, we reserve the right to refer uncollected balances to an outside collection agency. By keeping lines of communication open and providing accurate information, you can be sure that your claims will be handled promptly and efficiently.

By signing below, I agree that I am ultimately responsible for payment of services provided to me. My signature below authorizes Dupage Internal Medicine of IL to release the information necessary to facilitate the payments of claims.

Signed: _____ Date: _____/_____/_____