

PATIENT REGISTRATION FORM

Date: _____

Referred By _____

1. Patient Information:

Last Name		First Name			Middle Initial
Street Address		Apt. #	City	State	Zip Code
Home Phone #		Social Security #		Sex M F	DOB - Month Date Year
Cell Phone #		Patient's Employer		Patient's Work #	
Patient's Employer Address				Patient's Working Hours	
Patient's Marital Status S M D W	Spouse's Name		Maiden Name		
Patient's Email					

2. Insured/Responsible Party Information: If the patient and the insured are the same, please skip #2 and complete number 3.

Last Name		First Name			Middle Initial
Street Address		Apt. #	City	State	Zip Code
Home Phone #		Social Security #		DOB - Month Date Year	
Insured's Occupation	Insured's Employer		Insured's Work #		
Insured's Employer Address				Insured's Working Hours	

3. Emergency Contact Information

Last Name		First Name	
Home Phone #		Work Phone #	

4. Insurance Information: Office Use Only.

Name of Primary Insurance	Group # (If IDPA, please include case ID number)	Identification #:
Name of Secondary Insurance	Group # (If IDPA, please include case ID number)	Identification #:

HEALTH HISTORY AND DATABASE

Please complete both sides of this form completely. All information is confidential and is reviewed by your physician.

Name _____

Today's Date _____ Birth Date _____ Age _____

What is the reason for your visit?

Place a ✓ next to conditions you have now or have had in the past.			
<input type="checkbox"/> AIDS or HIV positive	<input type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Psychiatric disorder
<input type="checkbox"/> Alcohol or drug addiction	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Mumps	<input type="checkbox"/> Urinary infections
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate disorder	

List Hospital Admissions, Operations, Illnesses, and Serious Injuries (not including pregnancies)	Year	Illness or operation	Year	Illness or operation

List all medications you are now taking including over the counter medications, supplements and vitamins.	Medication allergies	Vaccine	Year of last	Test/exam	Year of last
		Tetanus		Tuberculosis	
		Flu Shot		Cholesterol	
		Pneumonia		Eye exam	
Date of last complete physical? _____					

Females only-please complete.	
Number of pregnancies	Birth control method
Number of live births	Date of last menstrual period
Number of abortions	Date of last pap smear
Number of miscarriages	Date of last mammogram

Family history	If any blood relative has suffered any of the following, please indicate below with a ✓.				
	Mother	Father	Brother or Sister	Child	Grandparent
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeds easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptoms: Mark (c) for current problems or check (✓) for past problems

<p>Constitutional</p> <input type="checkbox"/> Chills <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Loss of appetite (recent) <input type="checkbox"/> Sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular pulse/palpitations <input type="checkbox"/> Leg pain when walking <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Varicose veins/phlebitis	<input type="checkbox"/> Loss of bladder control <input type="checkbox"/> Painful or frequent urination <input type="checkbox"/> Urethral discharge <input type="checkbox"/> Venereal disease	<input type="checkbox"/> Non-healing sore <input type="checkbox"/> Persistent rashes <input type="checkbox"/> Psoriasis or eczema <input type="checkbox"/> Skin cancer or tumors
<p>Eyes</p> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Eye infections frequent <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing vision	<p>Respiratory</p> <input type="checkbox"/> Asthma or wheezing <input type="checkbox"/> Bronchitis or chronic cough <input type="checkbox"/> Pneumonia or pleurisy <input type="checkbox"/> Shortness of breath	<p>Males only</p> <input type="checkbox"/> Discharge from penis <input type="checkbox"/> Erectile difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Sore on genitals	<p>Neurological</p> <input type="checkbox"/> Dizzy or room spins <input type="checkbox"/> Frequent or severe headaches <input type="checkbox"/> Memory loss <input type="checkbox"/> Numbness/tingling sensations <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
<p>ENMT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Ear infections <input type="checkbox"/> Ear pain <input type="checkbox"/> Hoarseness <input type="checkbox"/> Painful swallowing <input type="checkbox"/> Recurrent nose bleeds <input type="checkbox"/> Ringing in ear <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Sore throats	<p>Gastro-intestinal</p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating <input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Constipation <input type="checkbox"/> Gallbladder problem <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Jaundice or Hepatitis <input type="checkbox"/> Persistent nausea or vomiting <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Vomiting blood	<p>Females only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Irregular cycle <input type="checkbox"/> Menstrual flow is heavy <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Painful menstruation <input type="checkbox"/> Vaginal discharge	<p>Psychiatric</p> <input type="checkbox"/> Depression <input type="checkbox"/> Excessive moodiness <input type="checkbox"/> Mental illness <input type="checkbox"/> Nervousness <input type="checkbox"/> Phobias <input type="checkbox"/> Sleeping difficulty
<p>CV</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells <input type="checkbox"/> Heart murmur	<p>Allergy/Immunology</p> <input type="checkbox"/> Hay fever or allergies <input type="checkbox"/> Hives <input type="checkbox"/> Severe allergic reaction	<p>Skeleton and Muscles</p> <input type="checkbox"/> Arthritis or rheumatism <input type="checkbox"/> Back pain <input type="checkbox"/> Bone fracture or joint injury <input type="checkbox"/> Cold feet <input type="checkbox"/> Gout <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Osteoporosis or thin bones	<p>Endocrine</p> <input type="checkbox"/> Excessive hunger/thirst <input type="checkbox"/> Flushing/menopause <input type="checkbox"/> Frequently cold <input type="checkbox"/> Frequently hot <input type="checkbox"/> Hot Flashes
	<p>GU</p> <input type="checkbox"/> Decrease in urine force/flow	<p>Skinner</p> <input type="checkbox"/> Change in moles <input type="checkbox"/> Easy bruising <input type="checkbox"/> Lump in breast or nipple <input type="checkbox"/> Nipple discharge	<p>Hematologic/Lymphatic</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Swelling/lump in armpits <input type="checkbox"/> Swelling/lump in groin <input type="checkbox"/> Swelling/lump in neck

Health Risk Assessment (Please describe any that apply.)

Tobacco use	Caffeinated beverages
Alcohol use	Occupation
Drug use	Exposure to hazardous substances
Intravenous drug use	Regular exercise
Do you have any special needs related to cultural beliefs? (i.e. diet, blood transfusions, religious practices- if so describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any special educational or communication needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any physical developmental or learning disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any food allergies or intolerances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please check (✓) next to items you have in your household.	<input type="checkbox"/> Smoke detector <input type="checkbox"/> Carbon dioxide detector <input type="checkbox"/> Firearms or weapons <input type="checkbox"/> Fire extinguisher
Do you routinely wear your seatbelt?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear a helmet while biking or rollerblading?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been a victim of domestic violence abuse or sexual assault?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you practice safe sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of partners in; 1) last year, 2) lifetime?	
Information completed by patient's family member or significant other?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous physician and or office location with your medical records?	
Is English your primary language? If not, what is?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The information above is accurate and complete to the best of my knowledge.	
Signature	Date
Reviewed	Date

Lincoln Park Family Physicians S.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Lincoln Park Family Physicians S.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lincoln Park Family Physicians' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent. Lincoln Park Family Physicians S.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lincoln Park Family Physicians' Privacy Officer at 1317 W. Diversey, Chicago, Illinois 60614.

With my consent, Lincoln Park Family Physicians S.C. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, collection calls and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Lincoln Park Family Physicians S.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Lincoln Park Family Physicians' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lincoln Park Family Physicians S.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient Name

Date

Print Name of Patient or Legal Guardian