Hedges Clinic

Patient Registration Form

Patient Information: **Today's Date:** _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: ☐M ☐F

Address: _____
ADDRESS CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Preferred Method of Communication: ☐ Home Number ☐ Cell Number ☐ Other: _____

Marital Status: ☐Single ☐Married ☐Other: _____ Employment Status: ☐FT ☐PT ☐Retired ☐ Student ☐N/A

If minor, who is responsible party? _____

Emergency Contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

Preferred Pharmacy: _____ Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

Ethnicity (check one):
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Refused to Report

Primary race (check one):
- ☐ White
- ☐ Hispanic
- ☐ African American/Black
- ☐ Asian
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Unreported/Refused

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____

Do you have an advanced directive such as a living will or medical power of attorney? ☐ Yes ☐ No

Is your visit with us today due to an automobile accident or work place accident? ☐ Yes ☐ No

Have any other member of your household been to this office? ☐ Yes ☐ No

If yes please list names: _____

Responsible Party (Guarantor):

Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____
ADDRESS CITY STATE ZIP

Employer: _____ Employer Address: _____
ADDRESS CITY STATE

Home Phone: _____ Cell Phone: _____ Work: _____

Relationship to Patient: _____ Employment Status: ☐FT ☐PT ☐Retired ☐ Student ☐N/A

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

IMMUNIZATIONS: *Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

Signature: _____ *Date:* _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

Hedges Clinic, S.C.
222 Colorado Ave
Frankfort, Illinois 60423
815-469-2123

Patient Name: _____

Date of Birth: _____

*****SIGNATURE OF THIS FORM DOES NOT RELIEVE PATIENT OF THE RESPONSIBILITY TO PROVIDE HEDGES CLINIC WITH ACTUAL INSURANCE CARDS OR DOCUMENTATION*****

ASSIGNMENT TO PAY BENEFITS TO PHYSICIAN:

I hereby assign payment by my insurance company (or third party who might be responsible for paying medical services) directly to Hedges Clinic, S.C. of Frankfort, Illinois. I agree to be responsible to Hedges Clinic; S.C. for charges not covered by this assignment, and hereby authorize Hedges Clinic, S.C. to obtain my credit report from any or all of the credit reporting agencies. I agree to be liable for any charges not paid by my insurance company that were incurred by children or dependents of mine over the age of eighteen years who are listed or covered under my health insurance. I furthermore agree to be liable for reasonable attorney fees and court costs incurred by the medical provider and agree that the proper venue for any legal action is Will County, Illinois in the event I fail to pay the amounts due for services rendered and this account is sent to any attorney for collection.

Signature: _____ *Date:* _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Hedges Clinic S.C., to release any information acquired in the course of examination or treatment to my insurance company (or third party who may be responsible for payment of medical services).

Signature: _____ *Date:* _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Disclose messages only to me

☐ Disclose any and all of my medical records/information to:

_____
NAME RELATIONSHIP

_____
NAME RELATIONSHIP

☐ Home Phone: _____ Cell Phone: _____

☐ O.K. to leave message with detailed information on answering machine/voicemail

☐ Leave message with call-back number only

☐ Work Phone: _____

☐ O.K. to leave message with detailed information on voicemail

☐ Leave message with call-back number only

☐ Email Address: _____@_____

☐ O.K. to leave message with detailed information

☐ Written Communication:

☐ Contact me at the following address:

_____
Street City/State Zip

****

Signature: _____ Date: _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

Patient Name: _____ Patient Date of Birth: _____

Hedges Clinic, S.C.

222 Colorado Ave
Frankfort, Illinois 60423
815-469-2123

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby give my consent to ***Hedges Clinic, S.C.*** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
PATIENT NAME

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the Hedges Clinic S.C. reception desk.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature: _____ *Date:* _____
PATIENT/GUARDIAN **RELATIONSHIP TO PATIENT**

Consent Form Definitions

"Health care operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under the supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities related to creation, renewal, or replacement of contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning related analyses related to operating the entity, including formulary development and administration, development or improvement methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities related to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related healthcare data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information.

Advocate Physician Partners

SynAPPs

HIPAA Privacy Statement - Addendum

This practice participates in a Health Information Exchange program where key clinical information about our patients' care is shared electronically, through a secure web portal, between this practice and other physicians/providers also providing care to our patients. Basic health information is shared with other treating physicians and providers. Sharing of basic health information in a Health Information Exchange is done so to have information available to better care for patients and the information is used for no other purposes.

LATER, if you decide that you no longer wish to participate, any information in The Health Information Exchange cannot be removed, but it will not be viewable because the patient identifying information will be inactivated. If you wish to exclude your basic health information from being included in this program, please inform the practice manager. You will be asked to sign a form documenting your wishes to "Opt-out".

The following information is defined by the State of Illinois as specially protected health information and should ***only***be shared with the patient's written permission in the Health Information Exchange, eEHX. This specially protected information includes information concerning alcoholism treatment, drug abuse treatment, mental health services, developmental disabilities services, genetic testing and treatment, testing and treatment for HIV/AIDS/Sexually Transmitted Disease, treatment for child abuse/neglect, and treatment of sexual assault or abuse.

We have taken precautions to try and exclude this information from the Health Information Exchange, but there still is a small possibility that this information may be inadvertently sent to the HIE. **Therefore, if you have specially protected health information you should "Opt-out" of participating in the eEHX, or sign a consent that allows release of your specially protected health information.**

This practice also participates with the **Illinois State Immunization Registry and Public Health Disease Surveillance Registry**. Information will be sent electronically to the IL State registries about immunizations and state-required reportable diseases. This information is used by the State of IL to track Public Health needs. If you do not want your immunization information to be reported to the IL State Immunization Registry you may request to "Opt out" of this by signing an Opt-out form. This will not affect your care by your doctor.

Advocate Physician Partners

SynAPPs

Specially Protected Health Information Authorization Form

Authorization to use and/or disclose protected health information in the Electronic Health Information Exchange.

____YES. I authorize this practice to use and/or disclose a copy of my protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw permission my protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

_____

Authorized date(s) or date range

_____

Printed Name of Patient/Representative

_____ _____

Signature of Patient/Representative Date

AUTHORIZATION OF REPRESENTATIVE:

I,_____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient _____

[A signed copy of this permission will be provided to the patient/representative]

HEDGES CLINIC

Patient Self History (Please complete BOTH pages completely)

Patient Name: _____ Date: _____

Address: _____
CITY STATE ZIP

Birthdate: _____/_____/_____ Soc. Sec. No. _____-_____-_____

Email Add: _____@_____

MEDICAL CONDITIONS: Please check all past or present medical problems and/or symptoms.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Tendancies
- ☐ Blood in Stool
- ☐ Cancer _____
- ☐ Chest Pain
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Drug/Substance Abuse
- ☐ Easily Bruised
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibroids
- ☐ Gastrointestinal Bleeding
- ☐ Glaucoma
- ☐ Gout
- ☐ Head/Neck Injury
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Blood Cholesterol
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Kidney Disease
- ☐ Knee/Thigh Injury
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Prostate Disease
- ☐ Psychiatric Problems
- ☐ Rectal Bleeding
- ☐ Rectal Polyps
- ☐ Recurrent Bronchitis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Incontinence
- ☐ Difficulty Urinating
- ☐ Abnormal Vaginal Discharge
- ☐ Abnormal Penile Discharge
- ☐ Visual Loss
- ☐ Other

MEDICATIONS: Please check all of the following medications that you are currently taking.

- ☐ 1. I am taking medication but do not know the name or its purpose.
- ☐ 2. Allergy medicines
- ☐ 3. Asthma medicines
- ☐ 4. Blood thinners
- ☐ 5. Diet pills
- ☐ 6. Diuretics (water pills)
- ☐ 7. Heart medicines (nitroglycerin, digitalis, rhythm medicines)
- ☐ 8. High blood pressure medicines
- ☐ 9. Insulin
- ☐ 10. Oral diabetes medicines
- ☐ 11. Thyroid hormones
- ☐ 12. Tranquilizers
- ☐ 13. Other

Specify exact names, dosages, and how often you take the medications you indicated above:

_____

_____

_____

ALLERGIES: List any medications or other substances that you are ALLERGIC to:

_____

_____

Social History: Do you smoke? If yes, how much and how often? _____

_____

****PLEASE TURN OVER****

Do you drink alcohol? If yes, how often and how much? _____

_____

Do you use illicit drugs? If yes, what kind and how often? _____

_____

What is your occupation? _____

Is there any exposure to dust, fumes, smoke, noise? _____

Are you watching your diet or following any strict dietary guidelines? _____

Do you exercise regularly? _____

Do you take any non-prescription medications, health foods, vitamins? _____

PLEASE LIST ANY PAST SURGERIES:

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

FAMILY HISTORY: (Immediate : father, mother, brothers, sisters, grandparents)

	Alive?	**Age**	**Medical Problems or Cause of Death**
Father			
Mother			
Other			
Other			

Health Screening/Immunizations: Please specify if you had any of the following:

Date & Results

Pap Smear	_____
Mammogram	_____
Bone Density	_____
Chest x-ray	_____
Physical Examination	_____
Digital Rectal Examination	_____
Prostate Examination/PSA	_____
Stool Hemoccults	_____
Flexible Sigmoidoscopy	_____
Colonoscopy	_____
Cholesterol	_____
Blood Sugar	_____
PPD/Tuberculosis Screening	_____
Influenza Vaccine	_____
Tetanus/TD	_____
Hepatitis B Vaccine	_____
Chicken Pox or Vaccine	_____
Body Mass Index	_____
Pneumovax	_____

Drs. Initials: _____ has reviewed this. UPDATED (yearly) _____

NAME: _____ D.O.B.: _____

Review of Systems: Please Indicate any personal history below: (Circle Yes or No)

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose Bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or Wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicles pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - # of pregnancies	_____	
Female - # of miscariages	_____	
Female - date of last pap smear	_____	

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (Skin, Breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes(insulin or non insulin - circle one)	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes
Change in hat or glove size	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibotics	No	Yes
Morphine, demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

Reviewed by _____ Date _____