Emery Medical Center
2380 S. Elmhurst Rd
Mount Prospect, IL 60056

PATIENT INFORMATION

Last Name	First Name	Birth Date	Sex	SS#
			Male / Female	
Home Address/Apt #	**City, State**	**Zip Code**	**Home Number**	**Cell Number**
Employer Name and Address			**Employer Phone Number**	
Ins. Card Holder's Name/ Date of Birth		**Email Address**		

PERSON RESPONSIBLE FOR BILL-PERSON TO RECEIVE STATEMENT

Name of Person Responsible for Bill	Telephone #
Responsible Party Mailing Address	**City/State/Zip code**

PLEASE TELL US HOW YOU HEARD/LEARNED ABOUT OUR OFFICE:

___ I was a **Former patient**

___ **Family/Friend/Co-Worker** recommendation

___**Office Sign**

____**Found on the Internet**

____**Printed Flyer Ad**

____**OTHER**: _____

By Signing Below:

I acknowledge the information in the front of this form to be accurate and complete.

I accept financial responsibility for any services rendered at Emery Medical Center if my insurance company OR responsible party does not pay. I understand that any past due balances over 90 days old will be subject to the following:

-Placed in "Office Collections" for an additional 30 days

.-After the additional 30 days, balanced owed will be turned over to **ARMOR COLLECTION SERVICES**

_____ _____

Patient or Authorized Person's Signature **DATE**

MEDICAL HISTORY FORM

PRINT FULL NAME: _____DATE:_____BIRTH DATE:_____

Do you have/or have had Any chronic problems with:	**YES**	**NO**	IF **YES**, Explain and when was this issue diagnosed	Current Treatment
Eyes/ Ears				
Headaches				
Nose				
Breathing/Chest/Lungs				
Stomach/Food Digestion/Bowels				
Heart				
Rectum/Constipation/Diarrhea				
Bladder/Kidneys				
Urination				
Blood Disorders				
Skin Disorders				
Immune Deficiency				
STD's				
Legs/Arms				
Depression				
Emotional Problems				
Sleep Disorders				
Personal/Work stress				
Ovaries/Uterus/Cervix				
Testicles/Penis				
FAMILY HISTORY Please mark appropriate intials (m) Mother (f) Father,(b) Brother, (s) Sister, Maternal Grandma /Grandpa(mgm/mgf), (pgm/pgf)Paternal Grandma/Grandpa				
Asthma				
Cancer (breast/prostate/other)				
Heart Disease				
Heart Attack				
High Blood Pressure				
Stroke				
Blood Disorders				
Diabetes				
Seizures				
HIV				
DO YOU:				***How Much***
Smoke				**#day/week**
Drink Alcohol				**#day/week**
Other Drugs				**#day/week**

Any Known Drug Allergies (if yes, please list below)

_____

Any Major Surgeries (if yes, please list below)

_____

By signing below; I acknowledge the information above to be accurate and complete. I also understand that if there are any changes to notify Emery Medical Center.

_____ _____ _____

Signature of Patient/Legal Guardian **Print Name** **Date**

Acknowledgment of Recent Notice Privacy Practices

I consent to the use or disclosure of my protected health information by Emery Medical Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Emery Medical Center. I understand that diagnosis or treatment of me by Emery Medical Center may condition upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry treatment, payment or healthcare operations of the practice, Emery Medical Center is not required to agree to the restrictions that I may request. However, if Emery Medical Center agrees to a restriction I request, the restriction is binding on Emery Medical Center, Dr. Shahid S. Sarwar, Dr. Rashmi C. Patel, and any other physician practicing at Emery Medical Center.

I have right to revoke this consent, in writing at any time, **EXCEPT** to the extent that Dr. Shahid S. Sarwar, Dr. Rashmi C. Patel, and any other physician practicing at Emery Medical Center has taken action in reliance on this consent.

"My Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Emery Medical Center's "Notice of Privacy Practices" prior to signing this document. Emery Medical Center's "Notice of Privacy Practices" has been provided to me. This notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Emery Medical Center. The "Notice of Privacy Practices" for Emery Medical Center is also provided at the registration desk at the office. The "Notice of Privacy Practices" also describes my rights and Emery Medical Center's duties with respect to my protected health information.

Emery Medical Center reserves the right to change Privacy Practices; I may obtain a revised notice of these changes by calling the office at 847-228-5557 or requesting a revised copy be sent through the mail, or asking for a copy at the time of my next visit.

_____ _____

Signature of Patient/Responsible Party **DATE**

_____ _____

PRINT Patinet Name **Relation of Responsible Party**