

**Welcome to Advocate Medical Group
Patient Registration**



PRIMARY PHYSICIAN NAME (LAST, FIRST) AND OFFICE LOCATION (CITY)

DATE

Patient Information (please print)

PATIENT NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

GENDER

M F

ADDRESS & UNIT NUMBER IF APPL.

CITY, STATE, ZIP CODE

MOBILE (CELL)

CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION?

YES NO

OTHER PHONE NUMBER

CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION?

YES NO

EMAIL ADDRESS (USED FOR PORTAL ACCOUNT/COMMUNICATION)

MARITAL STATUS

PREFERRED LANGUAGE

RACE (Optional)

ETHNICITY (Optional)

Account Guarantor if not the patient

GUARANTOR OF ACCOUNT (FINANCIALLY RESPONSIBLE PARTY)

NAME: ADDRESS: APT. / SUITE:

CITY: STATE: ZIP: PHONE:

Primary and Secondary Insurance with Subscriber Info (attach a copy of both sides of insurance cards)

Primary Insurance

Secondary Insurance

Insurance Name _____
Insurance Address _____
Insurance City/State/Zip _____
Group Number _____
Policy Number _____
Effective Date _____
Subscriber's Name _____
Subscriber's Date of Birth _____
Relationship to Patient _____

Emergency Contact

EMERGENCY CONTACT NAME (LAST, FIRST)

RELATIONSHIP TO PATIENT

CELL PHONE NUMBER

HOME PHONE NUMBER

WORK PHONE NUMBER

I authorize Advocate Medical Group to disclose my Patient Health Information to the following person(s)

NAME: PHONE NUMBER: RELATIONSHIP:

NAME: PHONE NUMBER: RELATIONSHIP:

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Advocate Medical Group and its agents to release any medical or incidental information that may be necessary for either medical care, to submit a health insurance claim, in processing applications for financial benefit, for quality assurance, or for Advocate Medical Group review for the purpose of medical research.

APPLICABLE TO MEDICARE PATIENTS:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to Advocate Medical Group for services rendered. I understand that I am financially responsible to Advocate Medical Group for charges not covered by this assignment. In some cases, your provider's fee is not covered in full by your insurance company. This balance due includes provisions set by your insurance company such as copayments, deductibles, and "usual and customary" allowance.

GUARANTEE OF PAYMENT:

In consideration of all medical services given by Advocate Medical Group to the patient named above, I agree to pay to Advocate Medical Group all fees and charges made for services, which may include the cost of collection and/or reasonable attorney's fees. Payment is due and payable within 30 days of billing date. A late charge may be added to the account for all charges not paid within 90 days.

I hereby certify that the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of these agreements as set forth. A photocopy of this form shall be valid as the original. I understand that it is my responsibility to notify Advocate Medical Group of any changes to the above information.

SERVICE CHARGE: A \$25.00 SERVICE CHARGE PER RETURNED CHECK WILL BE ASSESSED

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: DATE:

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY:

Our Notice of Privacy Practices ("Notice") provides information about: (1) the privacy rights of our patients; and (2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **AHC-CorporateHIPAA@advocatehealth.com** or a letter to:

**Chief Privacy Officer
Advocate Health Care
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515**

Phone: (630) 929-5922

By signing this form, you are only acknowledging that you have been provided our Notice.

Signature of Patient or Authorized Representative

Date of Signature

Print Name of Patient/Authorized Representative

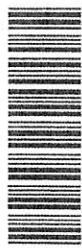
Date of Birth of the Patient or
Medical Record Number

Signature of Parent/Legal Guardian/Legal
Representative

Date of Signature

Parent/Legal Guardian/Legal Representative
Printed Name

Relationship to Patient



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Advocate Health Care

**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM**

Patient Label

AMG Orthopedics

Legal Name: (First) (Middle) (Last) Date of Birth Today's Date

Is this a WORKMAN'S COMP CASE? ☐ Yes ☐ No

Is legal action / litigation pending due to this injury? ☐ Yes ☐ No

Height Weight lbs. ☐ Rt. Handed ☐ Lt. Handed

REFERRED BY:

☐ ER/Acute Care Center ☐ Family ☐ Self ☐ Insurance Network ☐ Friend

☐ PCP: ☐ Community Event ☐ School: ☐ Internet ☐ Other:

PREFERRED PHARMACY

Name: Phone:

Address:

PRIMARY CARE PHYSICIAN

Name: Phone:

Address:

HISTORY OF PRESENT ILLNESS:

(Reason for today's visit, describe what happened):

☐ Work injury ☐ Fall ☐ Sports injury ☐ Car accident ☐ Other:

DATE of onset/Injury: Symptoms:

LOCATION of symptoms: ☐ Right ☐ Left ☐ Both ☐ NA

Check all that apply:

Level of Pain: (Least = 0; Greatest = 10) (Circle one) 0 1 2 3 4 5 6 7 8 9 10

Pain Quality: ☐ Sharp ☐ Throbbing ☐ Dull ☐ Aching ☐ Burning ☐ Cramping

Symptoms worsen with: ☐ Activity ☐ Walking ☐ Running ☐ Stairs ☐ Squatting ☐ Pivoting

☐ Overhead use ☐ Throwing ☐ Lifting ☐ Other:

Symptoms improve with: ☐ Rest ☐ Heat ☐ Cold ☐ Elevation ☐ Physical Therapy

☐ Brace ☐ Injection ☐ Medication ☐ None ☐ Other:

PREVIOUS TREATMENT/THERAPY:

☐ PT ☐ OT Other:

Diagnostic tests for this problem? ☐ X-Ray ☐ MRI ☐ US ☐ CT ☐ Other:

Test Location: Date:

A physician recommended surgery ☐ Yes ☐ No

Name of previous treating physician(s), if applicable:

AMG Orthopedics

SOCIAL HISTORY

☐ **Student** School: _____ Grade: _____ Sport: _____
☐ **Currently employed?** ☐ Disabled ☐ Retired from: _____ Occupation: _____
☐ **History of Smoking** ☐ Quit Smoking age _____ ☐ Current Smoker Packs per day: _____
Alcohol Use: ☐ Never ☐ Monthly ☐ Weekly ☐ Daily **Are you Pregnant:** ☐ Yes ☐ No

Past Surgical History		
Procedure:	Surgeon:	Date:
Procedure:	Surgeon:	Date:
Procedure:	Surgeon:	Date:

☐ **History of Anesthesia** ☐ **Problems with anesthesia:** Describe: _____

Past Medical and family History		
Has there been a recent change to your health? ☐ NO ☐ YES: _____		
	Self	Family
Eyes (e.g. blurred vision, double vision, loss of vision)	☐	☐
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	☐	☐
Cardiovascular (chest pain, palpitations, ankle swelling)	☐	☐
Respiratory (e.g. shortness of breath, cough, snore)	☐	☐
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	☐	☐
Genitourinary (e.g. burning, bleeding or difficulty urinating)	☐	☐
Musculoskeletal (e.g. joint, muscle, back or neck pain)	☐	☐
Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)	☐	☐
Neurological (e.g. numbness, tingling, weakness)	☐	☐
Psychiatric (e.g. depression, anxiety, memory loss)	☐	☐
Endocrine (e.g. weight gain/loss, excess thirst or urination)	☐	☐
Hematologic (e.g. bruising, bleeding or clotting disorder)	☐	☐
Diabetes Mellitus	☐	☐
Other Significant history:	☐	☐

Medications (Prescription/Over-the-Counter/ Herbal Supplements /Vitamins/Other)	Dosage	How Long?

ALLERGIES:

☐ Medication: Reaction:	☐ Latex Reaction:	☐ Other Reaction:
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Patient/Guardian Statement: To the best of my knowledge, the above information is accurate and complete.

PATIENT PRINTED NAME _____ DATE _____ TIME _____ PATIENT SIGNATURE _____

Guardian/Authorized Representative PRINTED NAME _____ DATE _____ TIME _____ SIGNATURE _____