Lake Street
FAMILY PHYSICIANS

HEALTH HISTORY QUESTIONAIRE

TODAY'S DATE:_____

PATIENT: _____DATE OF BIRTH:_____

1. CURRENT MEDICAL HISTORY

Reason for your visit today: _____

Do you have any **drug allergies**? ☐No ☐Yes If yes, please list:

Please list your **current medications**: **Drug Name** **Dosage** **Diagnosis or reason for medication**

2. PAST MEDICAL HISTORY

Are you currently being treated or have you been treated in the past for the following conditions:

CONDITION	DESCRIBE
Yes☐ No☐ Heart disease	_____
Yes☐ No☐ High cholesterol	_____
Yes☐ No☐ High blood pressure	_____
Yes☐ No☐ Lung problems	_____
Yes☐ No☐ Asthma	_____
Yes☐ No☐ Gastrointestinal problems	_____
Yes☐ No☐ Heartburn (reflux)	_____
Yes☐ No☐ Urinary tract infections, recurrent	_____
Yes☐ No☐ Arthritis	_____
Yes☐ No☐ Diabetes	_____
Yes☐ No☐ Thyroid problems	_____
Yes☐ No☐ Headaches	_____
Yes☐ No☐ Anemia	_____
Yes☐ No☐ Allergies	_____
Yes☐ No☐ Skin problems	_____
Yes☐ No☐ Cancer	_____
Yes☐ No☐ Ear, nose, throat or sinus problems	_____
Yes☐ No☐ Anxiety	_____
Yes☐ No☐ Depression	_____
Yes☐ No☐ Other	_____

HEALTH MAINTENANCE

Date of last Colonoscopy: _____ Name of Hospital or Facility: _____

For Women only:

Date of last PAP test: _____ Any abnormal PAP's? _____

Date of last Mammogram:_____ Any abnormal results? _____

Number of pregnancies: _____ Number of deliveries: _____

PATIENT: _____DATE OF BIRTH:_____

3. PAST MEDICAL HISTORY:

Have you had any surgeries? ☐Yes ☐No If yes, please list approximate date and type of surgery:

Date **Type of surgery**

Have you ever been hospitalized for reasons other than surgery? ☐ Yes ☐ No
If yes, reason:
Are you currently seeing other medical providers or specialists?

Physician's Name **Specialty**

ADULT VACCINES

Are you current with the following vaccines?
Tetanus: ☐Yes ☐No Date of vaccine:_____ Influenza: ☐Yes ☐No Date of vaccine:_____
Pneumonia: ☐Yes ☐No Date of vaccine:_____ Shingles: ☐Yes ☐No Date of vaccine:_____

4. FAMILY HISTORY

List all family members living in the patient's home:

Name	Relation	Birth Date	Health problems, if any

Please list any medical problems of the following relatives:
Father:
Mother:
Brother(s):
Sister(s):

If parent(s) is deceased, please list the age at time of death and cause of death:
Father – Age at time of death: Cause:
Mother - Age at time of death: Cause:

5. SOCIAL HISTORY

Occupation: _____☐Retired ☐Disabled ☐Student
Marital Status: ☐Married ☐Divorced ☐Single ☐Partner ☐Separated ☐Widowed
Do you have children: ☐Yes ☐No If yes, ages of children:_____
Your Hobbies:_____

Do you exercise? ☐Yes ☐No If yes, what type of exercise and frequency per week?
_____

Do you currently use **tobacco**? ☐Yes ☐No
If yes, what type of tobacco and how much **or #** packs?: _____
Have you used tobacco in the past? ☐Yes ☐No Date you quit: _____
Do you drink **alcohol**? ☐Yes ☐No If yes, how much per week?:_____
How often in the last year have you had more than 4-5 drinks in a sitting? _____# times
Did you ever have a drinking problem? ☐Yes ☐No _____
Do you currently use recreational drugs? ☐Yes ☐No If yes, what drugs and how often? _____
Have you used recreational drugs in the past? ☐Yes ☐No Did you ever have a drug problem? ☐Yes ☐No _____

Authorization and Consent Form

AUTHORIZATION OF CARE:
I hereby authorize Lake Street Family Physicians and staff to examine me and perform tests and procedures as they feel in their best judgment are reasonable and necessary in the diagnosis and treatment of my case. I acknowledge that no guarantees will be made to me as to the result of my treatment and/or examinations.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Lake Street Family Physicians and staff to furnish to my health insurance company and/or insurance company's review agency, or other third party insurance payor(s) or their designated agents, all the information the above named entities may request concerning treatment for myself and my dependents, including medical records.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS:
I hereby authorize Lake Street Family Physicians and staff the medical and/or surgical benefits to which I, or my dependents, are entitled under my health insurance plan. I guarantee payment in full for all amounts not covered by my health insurance company or other assigned third party payor(s). **I understand I will be responsible for payment of all co-pays, deductibles and non-covered services.**

CONSENT TO ELECTRONIC PHARMARY BENEFITS DATA EXCHANGE:
I hereby consent to enable Lake Street Family Physicians to obtain prescription formulary information and medications prescribed by any provider using Surescripts RxHub.

CONSENT TO IMMUNIZATION REGISTRY:
Immunization data may be reported to the State of Illinois Registry without the specific written authorization of patient or guardian. The patient or guardian or legal custodian may have the patient's record excluded from the Registry by completing Illinois' Immunization Registry Opt-Out Registry Form (Op-Out Form) and submitting the completed form to the provider.

I have read this form and understand its contents.

Patient Name (PRINT): _____

Signature: _____ Date: _____

Name and Relationship to patient: _____
(If signing on behalf of patient)

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for certain medical services or equipment may require that your relevant protected health information be disclosed to the health plan to obtain approval for medical services or equipment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 708-524-8600.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name:_____ Date: _____

Signature: _____

Relationship (if applicable): _____

Patient Financial Responsibility Policy

Thank you for choosing Lake Street Family Physicians as your primary care provider. We are committed to providing you with quality and affordable health care.

Please read our Patient Financial Responsibility Policy carefully and ask questions about any part of the policy. Your signature at the bottom is your agreement that you understand and agree to the payment requirements as outlined. We will provide you with a copy of the policy upon request.

1. **Insurance:** As a courtesy to our patients, we submit a claim to your insurance company for each service provided by Lake Street Family Physicians. Therefore, it is important that we always have your current insurance information. You will be asked to show your insurance card at each visit for verification. If we do not have current insurance information, you may be asked to make payment at the time of service.

   Knowing your insurance benefits is **your** responsibility. You will need to talk with your insurance company directly to determine if your physician and services rendered are covered under your specific group benefit plan.

2. **Co-payments, deductibles and outstanding balances:** All co-payments, deductibles and outstanding balances must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Non-covered services:** Please be aware that some of the services you receive may not be covered by your insurance benefit plan. It is your responsibility to know the benefits of your insurance plan.

4. **Claims submission:** We will submit your claims to your insurance company as a courtesy to you and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility and must be paid upon receipt of a billing statement from us.

5. **Insurance changes:** If your insurance coverage changes, please notify us ASAP so we can update your record.

6. **Nonpayment:** If your account is over 90 days past due, you will be asked to make a payment arrangement until balance is paid in full. If payment arrangements are not made in a timely manner, we may refer your account to a collection agency. You and your immediate family members may be discharged from our practice. You will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

7. **Missed appointments:** You will be charged **$25** for missed routine and follow-up appointments and **$50** for missed physical examination appointments that are not cancelled within **24 hours**. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment. As a courtesy, we will attempt to contact you to remind you of your appointment, however, it is your responsibility to keep track of your appointments.

8. **Medical Records:** There is a **$35.00** charge for copying and/or sending medical records.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Name:_____ Date: _____

Signature: _____

Relationship (if applicable): _____

Lake Street
FAMILY PHYSICIANS

PATIENT REGISTRATION FORM (Please Print)

DATE:_____

PATIENT INFORMATION

M F

LAST NAME | FIRST NAME | DATE OF BIRTH | GENDER

SINGLEMARPARTDIVWID | Am Ind Asian Black/Afr Am Hisp Pac Isl White/CauOther:_____

SOCIAL SECURITY # | MARITAL STATUS | RACE AND ETHNICITY

HOME ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE

HOME WORK CELL EMAIL

EMAIL ADDRESS | PREFERRED METHOD OF CONTACT

PATIENT'S RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self Spouse Parent Other:_____

LAST NAME | FIRST NAME | DATE OF BIRTH | SOCIAL SECURITY #

EMPLOYER | EMPLOYER ADDRESS | OCCUPATION

HOME ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE

INSURANCE INFORMATION

Primary Insurance Plan: _____ GROUP NO: _____ INSURED ID:_____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____RELATIONSHIP TO PATIENT: _____

Secondary Insurance Plan: _____ GROUP NO: _____ INSURED ID: _____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____RELATIONSHIP TO PATIENT: _____

PHARMACY INFORMATION

NAME OF PHARMACY | ADDRESS | CITY | STATE | ZIP

PHARMACY PHONE NUMBER | PHARMACY FAX NUMBER

EMERGENCY CONTACT INFORMATION

NAME | RELATIONSHIP | CELL PHONE | HOME PHONE