DES PLAINES MEDICAL ASSOCIATES

Des Plaines Clinic:
2118 Miner St., Des Plaines, IL 60016 Tel: 847-294-9600 • Fax: 847-294-9603
Villa Park Clinic:
638 N Addison Rd., Villa Park, IL 60181 Tel: 630-279-7703 • Fax: 630-279-7704
MAIN PHONE NUMBER: 630-990-9500

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____
First Initial Last

Address: _____ City:_____ State: _____ Zip :_____

Social Security # _____ Home Phone # (_____)_____

Work Phone # (_____)_____ Cell Phone # (_____)_____

E-Mail address _____ Sex: Male ☐ Female ☐

Parent or Legal Guardian Name: _____

Employer _____ Address: _____

Referred By: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

MEDICAL INSURANCE INFORMATION

Subscriber Name: _____

Relationship to Patient: _____ Carrier Name: _____

Policy #: _____ Group Name / Group # _____

Secondary Insurance Information:

Subscriber Name: _____

Relationship to Patient: _____ Carrier Name: _____

Policy #: _____ Group Name / Group # _____

EMERGENCY CONTACT: Name _____ Relationship: _____ Phone _____

ASSIGNMENT OF BENEFITS	**RELEASE OF INFORMATION**
I authorize payment of medical benefits to myself or the named provider for professional services rendered.	I authorize the release of any medical information necessary to process this claim.
Signed _____ (Subscriber/Patient) Date _____	Signed _____ (Subscriber/Patient) Date _____

CONSENT FOR TREATMENT/PATIENT AGREEMENT:

1. I request consent and authorize the administration and performance of all treatment and procedures including laboratory test which, in the judgment of the Physician, are considered necessary or deemed advisable.
2. I authorize DP Podiatry Inc, DBA Des Plaines Medical Associates to perform treatment considered necessary and I understand that the treatment and procedures will be performed by the Physicians and staff.
3. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding the result of treatment or examination in the clinic.
4. I am aware the Physicians reserve the right of not accepting me as a patient and the right termination of care to the patient at Physicians' own discretion at any point of service.
5. I am aware that the Physician reserves the right of termination of care due to inappropriate conduct or behavior and medical non-compliance, at any point of time during the treatment.
6. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

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PATIENT'S MEDICAL HISTORY

NAME : _____ Date of Last Physical Exam: _____

HEIGHT: _____ WEIGHT: _____ (For Podiatry Patients) Shoe Size _____ Width_____

CHIEF COMPLAINT:_____

_____

How long has this bothered you? _____

Are you taking any medications? ☐ YES ☐ NO If yes, please list, Include Vitamins, Herbs, Supplements, Oral Contraceptives, etc.

_____

_____

Do you smoke? ☐ YES ☐ NO Do you drink? ☐ YES ☐ NO

Have you had any past surgeries or hospitalizations? ☐ YES ☐ NO
If yes, please list, include Dates: _____
For WOMEN: Are you, to your knowledge, pregnant? ☐ YES ☐ NO

ALLERGIES: ☐ Penicillin ☐ Novocain ☐ Anesthetics ☐ Adhesive tape ☐ Latex ☐ Ibuprofen ☐ Iodine ☐ Sulfa

Other _____ ☐ **I am NOT allergic to anything that I know of.**

FAMILY HEALTH HISTORY:

	Check If Alive	Age at Death	Present Health or Cause of Death		Check If Alive	Age at Death	Present Health or Cause of Death
Father				Brother			
Mother				Sister			
Spouse				Child			

Have you or a family member of yours, ever had the following?

• Heart trouble	☐ You	☐ Family	• Epilepsy	☐ You	☐ Family
• Kidney trouble	☐ You	☐ Family	• Varicose Veins	☐ You	☐ Family
• High Blood Pressure	☐ You	☐ Family	• Arthritis	☐ You	☐ Family
• Liver Problems	☐ You	☐ Family	• Cancer	☐ You	☐ Family
• Circulatory Problems	☐ You	☐ Family	• Rheumatic Fever	☐ You	☐ Family
• Bleeding Tendency	☐ You	☐ Family	• Asthma	☐ You	☐ Family
• Depression	☐ You	☐ Family	• Diabetes	☐ You	☐ Family Last Blood Sugar_____

Other Health Conditions:

☐ Weakness	☐ Twitching	☐ Tremors	☐ Headaches	
☐ Dizziness	☐ Convulsions	☐ Epilepsy	☐ Fainting	☐ Numbness/Tingling
☐ Neck Stiffness/Pain	☐ Swollen Joints	☐ Arthritis	☐ Painful Joints	☐ Spinal Curvature
☐ Muscle Aches	☐ Low Back Pain	☐ Arm/Leg Pain	☐ Pain Between Shoulders	
☐ Bruise Easily	☐ Muscle Cramps	☐ Foot Pain, Left, Right or Both? _____		

Any other medical conditions or Injury? _____

Preferred Pharmacy Name _____City_____ Phone: _____

Primary Healthcare Physician, OB/GYN, other _____ Phone: _____

I certify the above information is complete, accurate and true to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____