PATIENT INFORMATION FORM

Last Name: _____ **First Name:**_____ **M.I.:** _____

Street: _____ **City:**_____ **State:** _____ **Zip:**_____

Date of Birth: _____/_____/_____ **Social Security#:** _____-_____-_____ **Gender** (circle one)**:** Male Female

Email Address:_____

In an effort to provide you with timely information regarding your health care, we are asking that you provide us with the following:

	Please circle one		
Daytime Phone Number: _____-_____-_____	Home	Work	Cell
Evening Phone Number: _____-_____-_____	Home	Work	Cell
Other Phone Number: _____-_____-_____	Home	Work	Cell

If you are not available at the time we try to call you, may we:

Disclose Medical information on an answering machine: Yes No N/A

Leave appointment information on an answering machine: Yes No N/A

Emergency Contact Person: _____ **Relationship:**_____

Emergency Contact Phone (Home)**:** _____-_____-_____ (Work): _____-_____-_____

Is this visit for the purpose of (circle one): workers' comp auto-accident personal self pay

It is the responsibility of the patient to contact us with any changes to the above information in writing.

Primary Medical Doctor:_____ **City:**_____

Referring Physician:_____ **Phone:** _____-_____-_____

PATIENT PRIVACY ACT / INFORMATION AUTHORIZATION

The following person(s) can inquire, pick up records, prescriptions, x-rays, etc., and take messages regarding my health information: (Please include any physicians, friends, or relatives to whom you may allow to take part in caring for your health)

1._____ Relationship_____

2._____ Relationship_____

3._____ Relationship_____

Signature: _____ **Date:** _____/_____/_____

Name of Authorized Guardian if patient is a minor:_____

PATIENT HEALTH HISTORY

G&T SPORTS MEDICINE ORTHOPAEDICS

Patient Name: _____ **Date of Birth:** ____/____/____

List medications you are currently taking: _____

_____

Allergies: None (circle if none)_____ **Previous Surgery**(ies)**:** Y N_____

FAMILY HISTORY:

Heart Disease____ Diabetes____ Hypertension____ Bleeding Problems____ Other_____

Do you smoke? Y N If you do, how much a day?_____How many years?_____

Do you drink alcohol? Y N If you do, how much a day?_____For how many years?_____

Do you/have you previously used drugs? Y N **Do you live alone?** Y N

Any information you provide will not be released and will only be used for the purpose of our office.

Please circle conditions you currently have or have had:

Anemia	Cancer	Gout	Migraine Headaches	Rheumatic
Anorexia	Cataracts	Heart disease	Mononucleosis	Scarlet Fever
Appendix	Chickenpox	Hepatitis	Multiple Sclerosis	Stroke
Arthritis	Diabetes	Hernia	Mumps	Thyroid Problem
Asthma	Emphysema	High Cholesterol	Pacemaker	Tuberculosis
Bleeding Disorders	Epilepsy	High Blood Pressure	Pneumonia	Typhoid Fever
Breast Lump	Glaucoma	Kidney Disease	Polio	Ulcers
Bronchitis		Liver Disease	Prostate Problem	Venereal Disease
Bulimia		Measles		

Please circle conditions you currently have or have had:

AIDS/HIV Positive Alcoholism Chemical Dependency Psychiatric Care

Please circle symptoms you currently have or have had <u>in the past 3 months:</u>

<u>GENERAL</u>
Chills
Depression
Dizziness
Fainting
Fever
Headache
Loss of sleep
Loss of weight
Gain of weight
Nervousness
Sweats

<u>MUSCLE/JOINT/ BONE</u> (Pain, Weakness, Numbness in)
Arms – Hips
Back – Legs
Feet – Neck
Hands – Shoulders

<u>GASTROINTESTINAL</u>
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Nausea
Rectal bleeding
Stomach Pain
Vomiting
Vomiting Blood

<u>SKIN</u>
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

<u>EYE,EAR,NOSE,THROAT</u>
Bleeding gums
Hoarseness
Nosebleeds
Persistent cough
Ringing in ears

<u>CARDIOVASCULAR</u>
High Blood Pressure
Irregular Heartbeat
Low Blood Pressure
Poor Circulation
Rapid Heartbeat
Swelling of Ankles
Varicose Veins
Chest Pain

<u>WOMEN ONLY</u>
Abnormal pap spear
Bleeding between periods
Breast Lump
Hot Flashes
Are you pregnant?__
No. of children___

<u>GENITO-URINARY</u>
Blood in urine
Frequent Urination
Lack of Bladder control
Painful Urination

ASSIGNMENT OF BENEFITS
& RELEASE OF INFORMATION

G&T SPORTS MEDICINE ORTHOPAEDICS

Commercial Insurance

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to (name of patient) _____.
I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian:_____

Medicare/Medicaid Insurance

Beneficiary_____Medicare Number _____Medigap ID Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Kevin C. Tu, MD, and Christos S. Giannoulias, MD, for any service furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

Beneficiary Signature:_____ **Date of Birth:** _____/_____/_____

Insurance Information: Who is the insurance policy subscriber? _____

Name of Insurance Plan/Group: _____ **Subscriber's Social Security #:** _____-_____-_____

Subscriber's Employer: _____ **Effective Date of Insurance:**_____

Secondary Insurance Information:_____

Name of Insurance Plan/Group: _____

Please know your insurance. It is your responsibility. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance.

AUTHORIZATION OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, or any other health plan to: Kevin C. Tu, MD and Christos S. Giannoulias, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
I hereby authorize said assignee to release all necessary information to insurance carriers or any other services including billing and transcription, concerning my illness and treatments in order to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature: _____ **Date:** _____/_____/_____

Name of Authorized Guardian if patient is a minor: _____

FOR WORKERS' COMPENSATION CASES

G&T SPORTS MEDICINE ORTHOPAEDICS

PLEASE FILL OUT AS MUCH AS POSSIBLE

Today's Date:_____/_____/_____

Patient Name: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Appt. Date: _____/_____/_____ Date of Injury: _____/_____/_____

****

Employer Name:_____

Employer Address: _____

_____

Contact Name: _____ Title: _____

Phone Number: _____-_____-_____ Fax Number: _____-_____-_____

****

Workers' Comp Carrier Name: _____

Address: _____

_____

Claim Number: #_____

Contact Name (Adjuster): _____

Contact Phone: _____-_____-_____ Fax Number: _____-_____-_____

Please note that Workers' Compensation benefits can be denied and you will be held responsible for all charges for rendered professional services.

G&T ORTHOPAEDICS
AND SPORTS MEDICINE

6374 North Lincoln Avenue
Suite 301
Chicago, IL 60659
773.463.2377

850 Biesterfield Road
Suite 2011
Elk Grove Village, IL 60007
847.439.2314

1200 South York Road
Suite 4190
Elmhurst, IL 60126
630.782.1174

Notice of Privacy Practices Acknowledgement

This notice advises you about the ways in which we may use and disclose your protected health information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you, which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of G&T Orthopaedics and Sports Medicine, S.C. Notice of Privacy Practices at the time of registration, or previously viewed online.

Signature_____Date_____

Notification del Reconocimiento de la Politica de Privacidad

Esta nota es para informarle a usted acerca de las formas en que nosotros podemos revelar su informacion protegida medica (PHI). Informacion protegida medica significa cualquier informacion medica que se pueda utilizar para identicarlo a usted y es posible que este relacionada con su salud o condicion fisica o mental pasada, actual, o futura y relacionados con servicios medicos. Tambien describe sus derechos y nuestras obligaciones con respecto a su informacion protegida medica. La ley requiere que nosotros le proveamos a usted esta nota de aviso en la cual se explican nuestras obligaciones legales y politicas de privacidad.

Con mi firma reconzco que me han ofrecido una copia del G&T Orthopaedic and Sports Medicine, S.C. Notice of Privacy al momento de registracion. Lo mismo pero en español.

Firma_____Fecha_____