ENDO-MED CLINIC, S.C.

Please Print

PATIENT INFORMATION

All information must be filled out in full

Todays Date:				PCP:	
Patient's Last name:	First	Middle		Marital status (circle one)	
				Single / Mar / Div / Sep / Wid	
Birth Date:	Age:	Sex: M F	Is this patient a minor? Yes No If yes please fill out parents information		
Street Address:				Home phone No: ( )	
	City:			State:	Zip Code:
SSN:			Cell Phone No:		
- -					

Please fill out information below if patient is a minor

Patients Mother's Info:	Birth Date:	Address if different	Home Phone:	
	/ /		Cell Phone :	
Employer:			Social Security No.	- -
Employer Address:			Employer Phone:	
Patients Father's Info:	Birth Date:	Address if different	Home Phone:	
	/ /		Cell Phone :	
Employer:			Social Security No.	- -
Employer Address:			Employer Phone:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Please note: In cases of divorce, it is our policy that responsibility of any amount left owed after insurance has paid will be the responsibility of the parent who brings the child for their appointments.

Primary Insurance Name:					
Subscriber's name:	Subscriber's SS no:	DOB: / /	Group #	Policy no:	Co payment $
Employer	Address			Phone:	
Patient's relationship to subscriber ☐ Self	☐ Spouse	☐ Child	☐ Other		
Secondary Insurance Carrier					
Subcriber's name:	Subcriber's S.S. no - -	DOB: / /	Group #	Policy no.	Co payment: $
Employer	Address			Phone:	
Patient's relationship to subscriber ☐ Self	☐ Spouse	☐ Child	☐ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone no: ( )	Work phone no: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that *I am financially resposible for the balance*. I authorize Joliet Doctors Clinic SC or Insurance company to release any information required to process my claims. I accept responsibility for any fees in absence of insurance. I also accept to pay all co-payments and coinsurance at the time the service is rendered.

Patient/Guardian signature Date

Endo-Med Clinic, S.C.
Surgical History

Do you smoke: _____Yes ____No

Do you drink alcohol: ____ Yes ___No

Circle all that apply:

No Surgery

Amputation	Appendectomy	Breast Biopsy
Cardiac Pacemaker	Cardiac surgery	Carpel Tunnel Release
Cervical Cone Biopsy	Cesearean Section	Colostomy
Endometrial Ablation	Gall Bladder	Hemmroidectomy
Hysterectomy	Knee Surgery	Laparoscopy
Lumpectomy	Masectomy	Oral Surgery
Ovarian Cystectomy	Spine Surgery	Splenectomy
Tonsillectomy	Tonsils and Adenoids	Thyroidectomy

Tubal Ligation

Other:

_____

ENDO-MED CLINIC, S.C.
PATIENT MEDICAL HISTORY

HAVE YOU OR YOUR FAMILY EVER HAD: (PLEASE CHECK ALL THAT APPLY)

DISEASE/DISORDER	YOU	FAMILY
ANEMIA	____	____
ANEURYSM	____	____
ARTHRITIS	____	____
ARTRIAL FIBRILATION	____	____
ASTHMA	____	____
BIPOLAR DISORDER	____	____
BRONCHITIS	____	____
CANCER	____	____
CARDIOMYAPATHY	____	____
CARPAL TUNNEL SYNDROME	____	____
CATARACTS	____	____
CHRON'S DISEASE	____	____
CHRONIC LUNG DISEASE	____	____
CIRRHOSIS	____	____
COLITIS	____	____
CONGENITAL HEART DISEASE	____	____
CONGESTIVE HEART DISEASE	____	____
CORONARY ARTER DISEASE	____	____
DEMENTIA	____	____
DEPRESSION	____	____
DIABETES	____	____
DIVERTICULOSIS	____	____
DIZZINESS	____	____
EAR INFECTIONS	____	____
EMPHYSEMA	____	____
ENDOMETRIOSIS	____	____
FIBROMYALGIA	____	____
GERD	____	____
GLAUCOMA	____	____
GOUT	____	____
HEADACHES	____	____

DISEASE/DISORDER	YOU	FAMILY
HEMORRHOIDS	____	____
HEPATITIS	____	____
HERNIA	____	____
HERNIATED DISC	____	____
HIV POSTIVE	____	____
HYPERCHOLESTEROLAMIA	____	____
HYPERTENTION	____	____
HYPERTHYROIDISM	____	____
HYPOTHYROIDISM	____	____
KIDNEY FAILURE	____	____
KIDNEY STONES	____	____
LIVER FAILURE	____	____
LUPUS	____	____
MACULAR DEGENERATION	____	____
MITRAL VALVE PROLAPSE	____	____
MRSA POSITIVE	____	____
MULTIPLE SCLEROSIS	____	____
OSTEOPOROSIS	____	____
PANCREATITIS	____	____
PARKINSONS DISEASE	____	____
PNEUMONIA	____	____
PULMONARY EMBOLISM	____	____
SCHIZOPHRENIA	____	____
SEIZURES	____	____
SICKLE CELL ANEMIA	____	____
STDS	____	____
THROMBOSIS	____	____
TUBERCULOSIS	____	____
ULCERS	____	____
URINARY TRACT INFECTION	____	____
UTERINE FIBROIDS	____	____
VARICOSE VEINS	____	____

ENDO-MED CLINIC

TRIAGE INFORMATION SHEET

When Endo-Med Clinic calls to report test results and the patient is not available we need the patient's permission to leave a message as instructed below:

1. Can we leave a detailed message on answering machine or voicemail:

YES NO

2. Please list all the people we can leave message with, please include phone number and relationship to patient:

_____

_____

_____

3. We can contact you at:

Home: _____

Cell: _____

Work: _____

4. Pharmacy Name, Location, Phone number: _____

_____

Print Name: _____ Date: _____

Signature: _____

PATIENT CONSENT FORM
ENDO-MED CLINIC S.C.
3033 W. JEFFERSON ST
SUITE 206
JOLIET IL 60435

I understand that under the health insurance portability and accountability act of 1996 (HIPAA) I have certain rights to privacy regarding my health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice o Privacy Practices* from time to time and that I contact this organization any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand that you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

Endo-Med Clinic, S.C.

It is the responsibility of the patient to call their insurance to verify that the providers at Endo-Med Clinic, S.C. are in the patients insurance network. In the case that your insurance company does not pay it will then be the patients responsibility to pay for the non-covered services.

Signature_____ Date _____