SUBURBAN LUNG ASSOCIATES

History Form

PATIENT NAME ______________________ **Date**______________________ **Sex** **M** **F**

Current Medications

Name	*Dose*	*Frequency*	*Name*	*Dose*	*Frequency*

Allergies to Medications	*Type of Reaction*	*Allergies (Other)*	*Type of Reaction*

Past Medical History

Medical Problem	*Date*	*Surgical Procedure*	*Date*

Hospitalization	*Location*	*Date*

Tests and Immunizations

Item (Most Recent)	*Yes*	*Year*	*No*
Chest X-Ray/Chest			
EKG			
Exercise Treadmill			
Allergy Skin Testing			
Flu Vaccine			

Item (Most Recent)	*Yes*	*Year*	*No*
Pneumonia Vaccine			
Pulmonary Function			
Sleep Study			
Sinus X-Ray/CT			
TB (PPD) Skin Test			

Family History

System	Diseases	Family Member/Age
Respiratory	**Emphysema/COPD**	
	Asthma	
	TB	
	Other	
Heart	**Heart attack**	
	Heart bypass surgery	
	Valvular heart disease	
	Hypertension	
	Stroke	
Endocrine	**Diabetes**	
	Thyroid	
	Other	
Cancer	**Lung**	
	Breast	
	Gastrointestinal	
	Other	

Social History

Past/Present Occupations:

Smoking History **Number of cigarettes/packs per day: _______**
Cigars Y N
Number of years smoked _______
If quit, (Date) _______________

Alcohol History **Number of drinks per day/week: _____**

Marital Status: **S M D W**

Highest level of education:

Pets:

Exercise:

With whom do you live?

Patient Name _____________________________________ Date ________________

Revised 10/02

SUBURBAN LUNG
ASSOCIATES

Account # ____________________

PATIENT INFORMATION

Please Print

Patient Name ____
First Middle Last

Social Security # ____________ Birthdate ____________ Home Phone ( ) ____________

☐ Minor ☐ Single ☐ Married ☐ Other ____________ Cell Phone ( ) ____________

Address ____________________________ City/State/Zip ____________

Patient/Parent's Employer ____________________ Work Phone ( ) ____________

Employer Address ____________________________ City/State/Zip ____________

Spouse/Parent's Name ____

Referring Doctor ____________________________ City/State ____________

Emergency Contact ____________________________ Phone ( ) ____________
Relationship

Email Address ____

RESPONSIBLE PARTY (If other than patient)

Name ____________________________ Relationship to Patient ____________

Address ____________________________ City/State/Zip ____________

Home Phone ( ) ____________ Work Phone ( ) ____________ Birthdate ____________

Drivers License # ____________ Social Security # ____________
(photocopy required)

INSURANCE INFORMATION

Name ____________________________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________________________ Work Phone ( ) ____________

Insurance Company ____________ Group # ____________ ID # ____________
(photocopy required)

Please complete the following if you have a secondary insurance or supplemental plan.

Name ____________________________ Relationship to Patient ____________

Name of Employer ____________________________ Work Phone ( ) ____________

Insurance Company ____________ Group # ____________ ID # ____________
(photocopy required)

I hereby consent and assign Suburban Lung Associates to furnish any and all records concerning my diagnosis and treatment to my insurer or other health care provider. A photocopy or fax of this consent shall be as valid as the original. I also assign benefits for all providers to Suburban Lung Associates.
I, the undersigned, acknowledge that I am financially responsible for professional services, procedures and tests performed at any of our office locations or in the event of hospitalization. I also give my permission for my treatment to be discussed with my family member or other care giver. Please list names:

____________________ ____________________ ____________________

____________________ ____________________ ____________________
Patient Signature (guardian required if under 18) Patient Name (please print) Date

800 Biesterfield Road, Suite 510 Elk Grove Village, Illinois 60007 ☎ 847-981-3660 Fax 847-956-5108
25 N. Winfield Road, Winfield, Illinois 60190 ☎ 630-690-4993 Fax 630-690-2293
333 Chestnut Street, Suite 104, Hinsdale, Illinois 60521 ☎ 630-734-8550 Fax 630-789-8405
1786 Moon Lake Boulevard, Suite 208, Hoffman Estates, Illinois 60194 ☎ 847-882-4082 Fax 847-882-4081

Agreement includes reverse side

REGISTRATION AND FINANCIAL POLICY

Thank you for choosing ***Suburban Lung Associates*** as your medical specialist. We are committed to providing high-quality, cost-effective health care. As part of our service to you and your family, we have summarized your financial responsibilities below.

INSURANCE

Our staff will file your insurance claim, for covered services, including Medicare, Public Aid and Worker,s Comp. We appreciate in over 40 health plans, however it is your responsibility to verify coverage **PRIOR** to your appointment. We will hold incomplete claims for 5 business days only. If you have not provided accurate information within 5 business days the full amount will be your responsibility. A copy of your driver,s license and insurance card(s) will be made upon registration.

REFERRALS

We **DO NOT** accept faxed referrals. You **MUST** bring an original referral to you appointment. If you do not have the required authorization, you will be asked to sign a referral waiver. This places you responsible for the full amount due until an original referral is received.

DEDUCTIBLES AND COPAYS

Many health plans require the patient to meet an annual deductible and often have routine copays for physician services. Check with your health insurance for specific details on the amount. Deductibles and copays are due at the time of service.

PAYMENT

Patient balances will be collected at the time of service. For your convenience we accept cash, check, or credit card (Master Card, VISA, Discover). A $15.00 charge will be assessed for all checks returned for "Insufficient Funds."

PAST DUE BALANCES AND COLLECTIONS

Our staff will assist you in making payment as easy as possible. Although we understand emergencies and hardship, we have a legal responsibility to collect on overdue accounts. Please contact the patient Accounts Department if you have extenuating circumstances. Payment arrangements for financial hardship may be considered but not guaranteed. Accounts more than 6 months old may be sent to collections.

MISSED APPOINTMENTS

Certain diagnostic tests require medication to be specifically mixed for each patient. Once mixed, these medications may be not be reused. If you are scheduled for a test in this category and need to reschedule please call at least 24 hours in advance. Otherwise a fee for the medication will be charged to your account.

PROTOCARE

A protocare staff member may contact me now or in the future for possible Clinical Research opportunities.

I have read and understand ***Suburban Lung Associates Financial Policy***.
Signature indicated on reverse side of form.