



Patient Information

(Please print)

If you do not understand any question, please ask for assistance.

Patient

Last name		First name		MI	Name called		Date
Street address		Apt #	City		State	Zip	County
Home phone #	Social Security #		Date of birth		Age	Marital status (circle which) S M W D	
Cell #	Pager #		Fax #		Business school #		
Email address					Best phone # and time range to be contacted		
Employer's name					Occupation		
Employer's address					City	State	Zip
School name		School address			City	State	Zip
(Spouse) or (Parent's) name (circle which)					Phone #		
Name of nearest friend or relative not living with you						Phone #	
First	Last		Relationship				

Primary Insurance

Please give insurance card to receptionist to photocopy

Policyholder's last name		First name		MI	Relationship to patient & date of birth			
Policyholder's address (if different than patient)					City	State	Zip	
Policyholder's SS#			Policyholder's employer's name					
Policyholder's employer's address					City	State	Zip	
Policyholder's business phone #								
Insurance company name								
Claims address					City	State	Zip	Phone #
Prior approval (not precert) address					City	State	Zip	Phone #
Insurance plan name/program name					Name of policyholder			
Policy #				Group #				
Does your insurance require pre-certification? <input type="checkbox"/> Yes <input type="checkbox"/> No					Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			



Secondary Insurance

Please give insurance card to receptionist to photocopy

Policyholder's last name		First name	MI	Relationship to patient & date of birth			
Policyholder's address (if different than patient)				City	State	Zip	
Policyholder's SS#			Policyholder's employer's name				
Policyholder's employer's address				City	State	Zip	
Policyholder's business phone #							
Insurance company name							
Claims address				City	State	Zip	Phone #
Prior approval (not precert) address				City	State	Zip	Phone #
Insurance plan name/program name				Name of policyholder			
Policy #			Group #				
Does your insurance require pre-certification? <input type="checkbox"/> Yes <input type="checkbox"/> No				Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Workman's Comp

Were you hurt on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of injury		
Name of employer/company where you were when you were hurt						
Supervisor/insurance clerk				Phone #		
Name of W/C insurance company			Address			
City	State	Zip	Claim #			
Claims adjuster				Phone #		
Last day worked				Date returned to work		

How did you hear about Illinois Plastic Surgery?						
OR-Referring physician				Phone #		
Address		City	State	Zip		
Primary care physician				Phone #		
Address		City	State	Zip		



Insurance Authorization and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and other health plans to Illinois Plastic Surgery, a division of Peoria Surgical Group, Ltd. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that my insurance company may not cover the procedure and/or services that I am receiving because it is considered a non-covered service. The insurance companies for reasons such as pre-existing condition, cosmetic procedures and diagnoses, and other reasons that they regulate, determine non-covered services. I agree to pay all fees for any diagnosis or procedure deemed non-covered as an out-of-pocket expense. I hereby authorize said assignee to release all information necessary to secure payment. I understand that all pathology studies and cultures sent out will be billed by the specified laboratories to me and/or my insurance. I understand that I am responsible for all deductible and co-payment amounts at the time of each visit in accordance to the guidelines and terms of my insurance policy. Further, I understand that any verification of provider or member eligibility status with a health plan and any description of benefits is not a guarantee of payment. All charges are paid based on benefits and eligibility status at the time that claims are received.

Signature:

Date:

Signature Authorizations

Release of Medical Information

I authorize the release of any medical or other information necessary to process claims pertaining to my medical or surgical treatment.

Signature:

Date:

If Above Patient Is A Minor

I authorize the staff to perform the necessary medical services my child may need.

Signature:

Date:



Patient History: History Intake Form

(Please print)

If you do not understand any question, please ask for assistance.

Last name	First name	MI	Date	Age
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Purpose of this consultation (location, quality, severity, duration, timing, context, med factors, assoc signs & symptoms)

Date of last physical exam	Doctor who performed exam	Doctor phone #
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List all physicians you are currently seeing (First & Last Name)

Do you have or have you had problems with...? (If yes, give date of occurrence)

AIDS or HIV <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Bleeding tendencies <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Thyroid <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Blood pressure <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Lupus <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Hearing <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Lungs <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Kidneys <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Nervous problems <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Fibromyalgia <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Gallbladder <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Bleeding problems <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Stomach <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Scleroderma <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Depression <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Melanoma <input type="checkbox"/> No <input type="checkbox"/> Yes _____

Other illnesses _____

Do you smoke regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes	How much/day? _____	Hx smoking _____	When quit? _____
Do you drink alcohol regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes	How much/day? _____	Type _____	
Have you ever had a blood transfusion? <input type="checkbox"/> No <input type="checkbox"/> Yes	If so, when? _____	And why? _____	

Med Hx & Review of Systems

Please list operations, surgeons, and year

Operation _____	Surgeon _____	Year _____	Hospital _____
Operation _____	Surgeon _____	Year _____	Hospital _____
Operation _____	Surgeon _____	Year _____	Hospital _____
Operation _____	Surgeon _____	Year _____	Hospital _____

Surgical Hx

Are you presently taking any of the following? (circle)

Aspirin/Anacin	Antibiotics	Blood pressure pills	Insulin/Diabetic pills
Bufferin	Dilatin	Cortisone	Blood thinness
Motrin	Hormones	Cough medicine	Digitalis
Ibuprofen	Thyroid pills	Birth control pills	Iron
Arthritis medication	Phenobarbital	Water pills	Vitamins

Please list your present medications (name, dose, amount, times/day)

1. _____
2. _____
3. _____
4. _____
5. _____

Use back of sheet if needed.

Do you take herbal supplements? Yes No

If yes, what are they? _____

Medications, substances or foods to which you are allergic (include type of reaction)

Latex allergy? Yes No

Medications



Family History

Have your blood relatives had...? (Circle and give type)

High blood pressure [] No [] Yes _____ Asthma [] No [] Yes _____
Diabetes [] No [] Yes _____ Goiter [] No [] Yes _____
Bleeding disorders [] No [] Yes _____ Breast cancer [] No [] Yes _____
Arthritis [] No [] Yes _____ Ovarian cancer [] No [] Yes _____

Other cancer _____

Is your birth father alive? [] Yes [] No
If no, age of death & primary cause _____

Is your birth mother alive? [] Yes [] No
If no, age of death & primary cause _____

Women Only

Is there a chance you may be pregnant? [] Yes [] No

MENSES

Do you have regular menses? [] Yes [] No
Date of last menstrual period _____

PREGNANCIES

How many pregnancies? _____ How many children? _____
Any complications with pregnancies? [] No [] Yes _____

BREASTFEEDING

Did you breastfeed? [] Yes [] No
How many children _____ Duration of breastfeeding _____

MAMMOGRAMS

Date of last mammogram _____
Facility name where mammogram was done _____
Obtained _____ Phone # _____
Normal or Abnormal (circle one)
Specify abnormality _____

BREAST CANCER

Have you been diagnosed with breast cancer? [] No [] Yes
L _____ R _____ Date _____
L _____ R _____ Date _____
Mastectomy (partial/completed) _____ Date _____
Surgical oncologist _____ Medical oncologist _____
Address _____ Address _____
Phone # _____ Phone # _____

I verify that the above information is true and accurate to the best of my knowledge.

Signature of patient or parent if minor: _____ Date: _____

OFFICE USE ONLY

Height _____ Weight _____ BP _____ Pulse _____ Respiration _____