EDWARD-ELMHURST HEALTH
REGISTRATION FORM
PLEASE **PRINT** ALL INFORMATION CLEARLY

PATIENT INFORMATION

Patient's **Legal** Name _____ **DOB** _____

Is address on ID current? ☐ Yes ☐ No If no, please enter current address below

Current Address
_____
_____
_____ _____
Zip Code

Home Phone (____) _____
Work Phone (____) _____
Cell Phone (____) _____

Email Address_____

Sex
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widow/Widower
☐ Separated

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Prefer not to answer

(State and Local governments may use the data to help plan and administer bilingual programs for people of Hispanic origin.)

Preferred Language _____
Preferred Pharmacy _____
Preferred Lab _____

Race
☐ White/Caucasian
☐ Black or African American
☐ American Indian/Alaska Native
☐ Asian
☐ Other Race
☐ Native Hawaiian and Other Pacific Islander
☐ Multi-racial
☐ Prefer not to answer

PCP (Primary Care Physician) Dr. _____

SSN _____
(required for access to our patient portal MyChart)

Employer Name: _____
Employment Status
☐ Full Time
☐ Part Time
☐ Not Employed
☐ Self Employed
☐ Retired
☐ Military Duty

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EEH Verbal Release of Information

Home Phone: _____ Cell Phone: _____ Work Phone: _____

1. Which phone number is best to use during the day (8am-4pm)? □ Home □ Cell □ Work

2. Which phone number is best to use during the evening (4pm-7pm)? □ Home □ Cell □ Work

3. If we may leave a detailed message regarding patient information which may include test results, appointment reminders or other health related services please check the box of your preferred voicemail*.

   □ Home □ Cell □ Work □ Do not leave a message

   ***Answering machines and voice mail must have an identifying message to confirm these are your numbers for example: ''You have reached John Doe" or ''You have reached 630-555-1212''**

4. Please list an **EMERGENCY CONTACT(S)** and any additional persons with whom we MAY share details about your health care.

In case of Emergency may we contact	Name	Relationship	Phone Number	Release Routine Info	Release Sensitive Info
☐ Yes ☐ No				☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

If Parent or Guardian's Signature

If you are filling this form out for your child remember to also list your name as an emergency contact and person to release information too.

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AGREEMENTS AND AUTHORIZATION

CONSENT TO HEALTHCARE SERVICES

- I, (the Patient signing below, or person signing below who is responsible for consenting on Patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants, or designees, and carried out by physicians or personnel at Edward Health Ventures DBA Edward Medical Group/Elmhurst Memorial Medical Group.
- I understand that I have the right to refuse this care, treatment or other services, as long as refusal is allowed under the law.
- I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments and medications, tests or examinations provided at Edward Health Ventures.
- I consent to photographs or other recordings to be used for the purpose of treatment, quality assurance, or education. I understand I have the right to refuse such recordings. The photo from your State Issued ID or Driver's License will be used in our system EHR for your protection and to prevent identity theft.

PAYMENT GUARANTEE

- In consideration of the services provided by Edward Health Ventures to Patient, I agree to: i) guarantee payment of all charges that are related to the services provided to the Patient; ii) for all time assign and transfer to Edward Health Ventures all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges; and iii) authorize payment of these benefits directly to Edward Health Ventures.
- I agree that Edward Health Ventures is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be.
- I agree to be fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits.
- Edward Health Ventures provides many services to assist uninsured patients as well as patients who cannot afford the cost of care. I understand that if I have any questions about Edward Health Venture's financial assistance policy I may ask the office supervisor during the registration process.

FOR MEDICARE PATIENTS

- I certify that any information given by me as the Patient or Patient Representative in applying for payment by Medicare is correct.
- I authorize any holder of medical or other information about Patient to release to Medicare or its agents any information needed for this or a related medical claim.
- I authorize payment of benefits to Edward Health Ventures on the Patient's behalf.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have been offered a copy of Edward's Notice of Privacy Practices. The Notice of Privacy Practices describes how the Patient's medical information may be used and disclosed by Edward Health Ventures and describes the Patient's rights with respect to this medical information.
- RELEASE OF INFORMATION FOR PAYMENT: I authorize Edward Health Ventures to release any and all relevant information about me from my records, including HIV, to any third party payors responsible for payment of charges, including insurance companies, health benefits plans, and waiver form if I do not want any information regarding my visit shared with my insurance company and understand that I will then become personally responsible for payment.
- EPIC CARE EVERYWHERE: We participate in Epic Care Everywhere. Care Everywhere allows health care organizations that use Epic electronic health record (EHR) and other participating systems to share your medical records via secure, encrypted connections for purposes of enabling your treating providers to access your medical records when treating you. Care Everywhere allows a treating physician real-time access to his or her patient's medical history, previous diagnoses, results of diagnostic tests (e.g., labs, cardiology, and radiology), medications, allergies, progress notes and other crucial medical information without having to wait for these records to be transferred from one facility to another. We will make your Edward-Elmhurst Health medical record, excluding any records related to your mental or behavioral health treatment, available to other health care organizations through Care Everywhere. When it comes to your PHI, you have certain rights. This section explains your rights and some of our responsibilities to help you. If you do not want your medical record to be shared through Care Everywhere, please contact our Edward Elmhurst Health Information Management Department at 331-221-6990 and ask them to complete the necessary steps to remove you from the Care Everywhere Program.

No revisions or changes to this form by you will be accepted by Edward Health Ventures.

This agreement and authorization form covers services I receive from Edward Health Ventures for a period of 365 days from the date of my signature below, unless revoked by me in writing sooner, or restricted to a shorter time period by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Patient Name: _____ DOB: _____
(Print)

_____

Signature of Patient or Patient's Representative (parent, guardian or other representative) | Relationship | Date

EDWARD/ELMHURST HEALTHCARE
Adult Patient Health History
For patients 18 years of age and older

NAME: _____ **DOB:** _____ **M / F**

PRIMARY CARE PHYSICIAN: _____ **DATE:** _____

Please fill out the following Annual Health History to the best of your ability.

NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

MEDICAL HISTORY

Serious Illnesses/ Injuries

_____ _____
_____ _____
_____ _____
_____ _____

Concussion or head injury? ☐ Yes ☐ No If Yes when? _____

Ever been knocked unconscious? ☐ Yes ☐ No If Yes when? _____

Previous Hospitalizations (Indicate Reason)	**When?**	**Hospital, City, State**

Surgeries and/or invasive procedures	**When?**	**Hospital, City, State**

ALLERGIES

List all allergies and reactions – (e.g. Penicillin – rash)

Medications: _____

Food: _____

Environment: _____

OTHER IMPORTANT INFORMATION

1. Do you have a history of tuberculosis? ____yes ____no
2. Have you been in close contact with someone with tuberculosis? ____yes ____no
3. Have you ever had a positive TB skin test? ____yes ____no
4. What country were you born in? _____

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset of menses _____
Regular? ☐ Yes ☐ No ☐ Varies
Cycle _____Days (from start to start)
Flow ☐ Heavy ☐ Medium ☐ Light
Post menopause ☐ Yes ☐ No
If yes age of onset _____
Date of last pelvic/pap _____
History of abnormal pap test ☐ Yes ☐ No
Date of last Mammogram _____
Do you take birth control pills? ☐ Yes ☐ No
If yes how long have you taken them? _____

Do you use Hormone Replacement Therapy ☐ Yes ☐ No
Pregnancies
How many children born alive ___ How many still births ___
How many premature births ____ How many c-sections___
How many miscarriages _____
How many elective abortions_____
Any children born over 9 pounds ☐ Yes ☐ No
Any history of gestational diabetes ☐ Yes ☐ No
Any complications with pregnancy ☐ Yes ☐ No
If yes describe _____

NAME: _____ **DOB:**_____ **M /F**

FAMILY MEDICAL HISTORY:

		Age	Diseases or Conditions	If Deceased, Cause of Death	Age at death
Father					
Mother					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Sibling	Sex				
Spouse/Life Partner					
Children	Sex				

SOCIAL HISTORY

Birthplace _____ Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Life partner ☐ Separated ☐ Divorced ☐ Widowed
Use of alcohol: ☐ Never ☐ Quit ☐ Daily Current amount/ per week: _____
Use of tobacco: ☐ Never ☐ Quit Type _____ Amount per day: _____
Use of drugs: ☐ Never ☐ Quit Type/Frequency: _____
Use of caffeine: ☐ None ☐ Less the 1-2 cups/can daily ☐ 3-4 cups/cans daily ☐ more than 5 cups/cans daily
Exercise: ☐ None ☐ No regular regimen ☐ Yes, how often_____
Excessive exposure at home or work to: ☐ Dust ☐ Fumes ☐ Noise ☐ Second-hand smoke ☐ Solvents ☐ Other
Use seatbelt regularly: ☐ Yes ☐ No
Have you had any recent falls? ☐ Yes ☐ No

OTHER IMPORTANT INFORMATION

Do you have any of the following?
Durable Power of Attorney for Health Care ☐ Yes ☐ No
Do Not Resuscitate order ☐ Yes ☐ No
Living Will ☐ Yes ☐ No
If yes please provide a copy for your medical record.
Do you wish to be an organ donor? ☐ Yes ☐ No
If yes, please discuss with your family members
Do you have a religious or cultural belief that may affect your choice of medical treatment? ☐ Yes ☐ No
If yes please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my heath. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of Patient or Guardian Date

Date reviewed/updated	Patient/Guardian Initials	Date reviewed/updated	Patient/Guardian Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____