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 _____

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

Edward-Elmhurst HEALTH | Healthy Driven

Consent for 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 detailed message, please check box of your preferred voicemail*.

   □ Home □ Cell □ Work

   ***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

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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/Elmhurst Health.
- 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/Elmhurst Health.

PAYMENT GUARANTEE

- In consideration of the services provided by Edward/Elmhurst Health 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/Elmhurst Health 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/Elmhurst Health.
- I agree that Edward/Elmhurst Health 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/Elmhurst Health 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/Elmhurst Health'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/Elmhurst Health 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/Elmhurst Health and describes the Patient's rights with respect to this medical information.

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

This agreement and authorization form covers services I receive from Edward/Elmhurst Health 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

_____

Signature of Witness to signing of form Printed Name

If Patient or Patient Representative did not sign this form, document the reason on the reverse side and sign.

EDWARD/ELMHURST HEALTHCARE

Pediatric Patient Health History

For patients under the age of 18

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.

IMPORTANT: If you are the Parent or Guardian, answer ALL questions on this form for the MINOR

BIRTH HISTORY

Birth Weight _____lbs. _____oz. Birth Hospital, city & state: _____

Type of delivery ☐ vaginal birth ☐ Cesarean Section/ Reason for Cesarean section: _____

Pregnancy complications: _____

Delivery complications: _____

Nursery complications: _____

Was prenatal care started within the 1st trimester of pregnancy? ☐ Yes ☐ No if no when was it started? _____

Other prenatal complications: _____

Are you adopted? ☐ Yes ☐ No

MEDICAL HISTORY

Serious Illnesses/ Childhood Illnesses

_____ _____

_____ _____

Past or present diagnosis of Asthma ☐ Yes ☐ No

Injuries				**When?**
Broken or fractured bones	☐ Yes	☐ No	If Yes what bones? _____	_____
Sprains	☐ Yes	☐ No	If Yes where? _____	_____
Lacerations	☐ Yes	☐ No	If Yes where? _____	_____
Dislocations	☐ Yes	☐ No	If Yes where? _____	_____
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? _____

PLEASE PROVIDE A COPY OF PATIENT'S IMMUNIZATION RECORD

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

FEMALES ONLY - MENSTRUAL HISTORY AS INDICATED

Age at onset of menses _____
Regular? ☐ Yes ☐ No ☐ Varies
Cycle _____Days (from start to start)
Flow ☐ Heavy ☐ Medium ☐ Light
Pains or cramps ☐ Yes ☐ No

Do you take birth control pills? ☐ Yes ☐ No
If yes how long have you taken them_____
Have you ever been pregnant? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY:

		Age	Serious Diseases or Conditions	If Deceased, Cause of Death	Age at death
Father					
Mother					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Sibling	Sex				

SOCIAL HISTORY

School _____

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 car seat/seatbelt regularly: ☐ Yes ☐ No
Have you had any recent falls? ☐ Yes ☐ No
Are there any guns in the house? ☐ Yes ☐ No

OTHER IMPORTANT INFORMATION

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 Parent or Guardian Date

Date reviewed/updated	Parent/Guardian Initials	Date reviewed/updated	Parent/Guardian Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____