SOUTHLAND
RHEUMATOLOGY CENTER

20060 Governors Drive, Suite 300 B, Olympia Fields, IL 60461
6857 Kingery Hwy, Willowbrook, IL 60527
www.southlandrheumatology.com ***phone:708-286-2600 fax:708-833-7248***

PATIENT REGISTRATION FORM

A new form must be completed Annually per insurance regulations.

PATIENT NAME:

Last Name: _____ **First Name**: _____ MI: _____

Gender: F☐ M☐ **DOB**: / /

Marital Status: Single☐ Married☐ Divorced☐ Widow/Er ☐

Address: _____ **City**: _____

State: _____ **Zip code**: _____

Cell Number : ( ) **Home Number**: ( )

Email: _____ **Social Security**: _____

Race**:** Declined☐ White ☐ Black/African American☐ Hispanic☐ Asian☐ Other☐

Ethnicity**:** Hispanic☐ non-Hispanic☐ Decline ☐ Language**:** English☐ Spanish☐ Other☐

Patient Employer: _____

Address:_____Phone: _____

Person Responsible for Bill: _____ DOB: / /

Address if different than Patient: _____

Pharmacy Name: Pharmacy Name: _____

Address: _____City: _____ State: _____ Zip code: _____

Referred By: _____ Primary Care Physician: _____

Emergency Contact Name

Contact Name: _____ Relationship: _____

Contact Number: ( ) Address: _____

City: _____State: _____ Zip code: _____

PRIMARY INSURANCE:

Name of Company: _____ Subscriber Name: _____

Subscriber DOB: / / Relationship: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE:

Name of Company: _____ Subscriber Name: _____

Subscriber DOB: / / Relationship: _____

Policy Number: _____ Group Number: _____

☐I acknowledge receipt of notice of privacy practices (HIPAA).

☐I authorize Southland Rheumatology Center to release information regarding services rendered and allow a photocopy of my signature to be used to file insurance.

☐I authorize and direct my insurer to issue payment for services directly to Southland Rheumatology Center. If my insurance is MEDICARE, I request the payment of authorized MEDICARE benefits, for any services furnished to me, to be made on my behalf, to Southland Rheumatology Center.

☐In the event of non-payment, I understand that I am responsible for collection, attorney, and court costs.

☐I authorize any holder of medical information about me to release to the HEALTHCARE FINANCING ADMINISTRATION and its agents any information needed to determine those benefits payable for related services.

Dr. Nayak is NOT a MEDICAID Provider.

FAILURE TO PROVIDE SECONDARY INSURANCE INFORMATION PRIOR TO VISITS WILL RESULT IN PATIENT BEING RESPONSIBLE FOR FULL BALANCE ON ACCOUNT WITHIN 90 DAYS.

Signature: **Date:**

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NEW PATIENT MEDICAL FORM

NAME: **DATE:**

Reason for your Visit Today?

Please list any RECENT Blood Test, X-Rays, MRI's, CT scans and Other Studies done in last 6 months and WHERE they were done?

List All your Medications with Dosages including Over the Centre Non-Prescriptive Supplements.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you have any ALLERGIES to any Medications? Yes ☐ No ☐ If yes, please list:

List any MEDICAL CONDITIONS /SURGERIES you have had, and Date of Diagnosis:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Height: **Weight:** **Pain Level on the Scale of 0-10:** _____
Do you smoke? No☐ Yes☐ If yes, how much _____
Do you Drink Alcohol? No☐ Yes☐ If yes, how much _____
Have you had Osteoporosis Screening w/Bone Density Test? No☐ Yes☐ If yes, when _____
Have you had a Pneumonia Vaccination? No☐ Yes☐ If yes, when _____

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Have you had COVID-19 Vaccination? No☐ Yes☐ If yes, when _____

Have you had Shingles Vaccination? No☐ Yes☐ If yes, when _____

SYSTEM REVIEW

Please Check Any Problems You Have Been Experiencing and For How Long in The Systems Review Below.

Fever☐	Chest Pain ☐	Difficulty Swallowing ☐
Chills☐	Irregular Heartbeat☐	Heartburn☐
Night Sweats ☐	High blood pressure☐	Stomach Pain☐
Recent Weight Loss☐	Shortness of breath☐	Diarrhea☐
Recent weight Gain☐	Cough ☐	Constipation☐
Fatigue☐	Wheezing ☐	Nausea☐
Difficulty Sleeping☐	Swollen Legs/Feet☐	Bleeding Ulcer☐
Neck Pain ☐	Back Pain☐	Loss of Appetite☐
Changes in Mood☐	Memory Problems☐	Thyroid Abnormalities☐
Dry Eyes ☐	Headaches☐	Skin Rash☐
Double/ Blurred Vision ☐	Dizziness/Imbalance☐	Sun Sensitivity Rash☐
Ringing in Ear ☐	Fainting☐	Excessive Hair Loss ☐
Frequent Nose Bleeds☐	Tingling/Numbness☐	Color Change Hands/Feet☐
Dry Mouth ☐	Muscle Weakness☐	Easy Bruising☐
Frequent Mouth Sores☐	Muscle Spasm ☐	Frequent Urination☐
Muscle Pain☐	Pain /burning w/ urination ☐	

In your Family is there a Medical History of:

Autoimmune Disease like Lupus or Rheumatoid Arthritis? No☐ Yes ☐Who_____
Osteoarthritis: No☐ Yes ☐ Who_____
Gout/Kidney Stones: No☐ Yes ☐ Who_____
Osteoporosis: No☐ Yes ☐ Who_____
Cancer: No☐ Yes ☐ Who_____
Heart Disease: No☐ Yes ☐ Who_____
Diabetes: No☐ Yes ☐ Who_____

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BILLING POLICY:

- Patient benefits will be verified with insurance company provider prior to office visit and co-pay will be collected at the time of service by cash or credit card (NO CHECKS). Deductibles will be collected in full at the time of follow up appointment.
- Patients with outstanding balances will be requested to pay the balance in full, prior to their appointment up by cash or credit card (NO CHECKS).
- Patients will receive no more than three monthly statements regarding an unpaid balance before a final letter is issued prior to sending to collections.

NO SHOW/CANCELATION POLICY:

- Any cancellation for an appointment without a 24-hour notice, depending on the circumstances of course there will be charge a $25 that will have to be collected at the time of your next visit by cash or credit card.
- If no you do not show up for an appointment there will be a $25 charge that will have to be paid at the time of your next visit.
- If you do not show up/cancel an appointments three times consecutively we will not be able to schedule any further appointments with our practices.

NOTICE TO ALL HMO PATIENTS

It is the patient's responsibility to obtain referrals for office visits. If for some reason you do not have a referral to cover services here in our offices, your appointment will be cancelled. Any office visits that do not have a referral to cover the services, the patient will be responsible for any balances left over, which your insurance will not cover without having a referral.

NOTE:

If you need to cancel your appointment prior to the scheduled date, and that we are not in the office, you are always welcome to leave aa message with our answering services.

PRINT NAME:

SIGNATURE: **DATE:**