SOUTHLAND
RHEUMATOLOGY CENTER

20060 Governors Drive, Suite 300 B, Olympia Fields, IL 60461
www.southlandrheumatology.com |708-283-2600

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: _____

Permission to view Prescription History from External Sources: ☐Yes ☐No

Primary Care Physician: _____ **Referred by:** _____

Emergency Contact Name

Contact Name: _____ Relationship: _____

Contact Number: _____ Address: _____

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) is on the above website and copy of it for the review is available upon request.

☐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 BALANCE ON ACCOUNT.

Signature: _____ **Date:** _____

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NEW PATIENT MEDICAL FORM

NAME: _____D.O. B: _____DATE: _____
Reason for your Visit Today?

_____

_____

Pain Level: Please indicate how severe your pain has been OVER THE PAST WEEK from scale 1-10? __

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?

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

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

1._____ 9. _____
2. _____ 10. _____
3._____ 11. _____
4. _____ 12. _____
5._____ 13. _____
6. _____ 14. _____
7._____ 15. _____
8. _____ 16. _____

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

_____

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

Medical Conditions	Date of Diagnosis	Medical Conditions	Date of Diagnosis
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

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

Surgery	Date of Surgery	Surgery	Date of Surgery
1.		4.	
2.		5.	
3.		6.	

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SYSTEM REVIEW

Please Check Any Symptoms You Are Currently Experiencing and For How Long.

☐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	☐ Memory Problems
☐Neck Pain	☐ Changes in Mood	☐Loss of Appetite
☐ Back Pain	☐Headaches	☐Thyroid Abnormalities
☐Dry Eyes	☐ Dizziness/Imbalance	☐Skin Rash
☐Double/ Blurred Vision	☐ Fainting	☐Sun Sensitivity Rash
☐Ringing in Ear	☐ Tingling/Numbness	☐Excessive Hair Loss
☐Frequent Nose Bleeds	☐ Muscle Weakness	☐Color Change Hands/Feet
☐Dry Mouth	☐ Muscle Spasm	☐Easy Bruising
☐Frequent Mouth Sores	☐ Muscle Pain	☐ Pain /burning /Frequent Urination

Do you smoke? ☐No ☐Yes ☐ If yes, how much _____
Do you Drink Alcohol? ☐No ☐ Yes ☐If yes, how much _____
Do you use CBD? ☐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 _____
Have you had COVID-19 Vaccination? ☐No ☐ Yes ☐If yes, when _____
Have you had Shingles Vaccination? ☐No ☐Yes ☐If yes, when _____

FAMILY HEALTH HISTORY	SIGNIFICANT HEALTH PROBLEMS
Father	
Mother	
Siblings	
Children	

Is there a Family Medical History of?
Autoimmune Connective Tissue Disease like Lupus or Rheumatoid Arthritis?
☐No ☐Yes ☐If yes, who _____
Osteoarthritis: ☐No ☐Yes ☐ If yes, who _____
Gout/Kidney Stones: ☐ No ☐Yes ☐ If yes, who _____
Osteoporosis: ☐No ☐Yes ☐ If yes, who _____
Cancer: ☐No ☐Yes ☐ If yes, who _____
Heart Disease: ☐No ☐Yes ☐ If yes, who _____
Diabetes: ☐No ☐Yes ☐ If yes, who _____

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BILLING POLICY:

- Patient benefits will be verified with insurance prior to your office visit and co-pay will be collected at the time of service by cash or credit card (NO CHECKS).
    - ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE.
    - Deductibles will be collected in full at the time of follow up appointment, after insurance has processed claims.
- Patients with outstanding balances will be requested to pay the balance in full, prior to their appointment, by cash or credit card (NO CHECKS).
- If amount remains unpaid after 90 days, the account will be referred to collection agency and an additional 10% fee will be applied to cover collection fee.

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 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 *3 times consecutively,* we will not be able to schedule any further appointments with our practice.

NOTICE TO ALL HMO PATIENTS

It is the patient's responsibility to obtain valid updated referrals for each office visit. If for some reason you do not have a referral to cover services here in our office, 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 balance, which your insurance will not cover without having a referral.

NOTE:

If you need to cancel your appointment prior to the scheduled date, and we are not in the office, you are always welcome to leave a message with our answering service at 708-283-2600.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

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PATIENT CONSENT FORM

☐ I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed the *Notice of Privacy Practices* containing a more complete description about the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Southland Rheumatology Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

HIPPA DISCLOSURE AUTHORIZATION

☐ I authorize Southland Rheumatology Center to speak with and disclose information about my medical conditions to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, further authorize Southland Rheumatology Center to contact me and leave messages on:

Home Phone: _____ Cell phone: _____

Email: _____

This authorization will remain in place until rescinded by me.

_____ _____
Patient Name Patient Signature

Date: _____