FOX VALLEY PHYSICIAN SERVICES, S.C.

Patient Registration Form

(Please Print Clearly)

23 North Lincolnway
North Aurora, IL 60542
Phone 630-966-2637
Fax 630-966-1611
http://fvps.net/

PATIENT INFORMATION

Name:_____	Date of Birth:_____
Address:_____	Home Phone:_____
City, St:_____ Zip:_____	Mobile Phone:_____
Soc. Sec. #:_____	Email:_____
Marital Status: ❑ Single ❑ Married ❑ Divorced	Gender: ❑ Male ❑ Female

INJURY INFORMATION

Car Accident	❑ Yes ❑ No
Work Injury	❑ Yes ❑ No
Personal Injury	❑ Yes ❑ No

EMERGENCY CONTACT

Name:_____
Home Phone:_____
Mobile Phone:_____

WORK INFORMATION

Employer:_____	Work Phone:_____
Address:_____	Job Description:_____
City, St:_____ Zip:_____	_____

DEMOGRAPHIC INFORMATION

Race:	❑ American Indian or Alaskan Native	
	❑ Asian	❑ Other
	❑ Black	❑ Pacific Islander
	❑ Caucasian	❑ Decline
Ethnicity:	❑ Hispanic ❑ Non-Hispanic ❑ Decline	

HOW DID YOU FIND US?

❑ Referral	Name:_____ Phone:_____
❑ Phone Book	
❑ Internet	Please explain:_____
❑ Other	Please explain:_____

PRIMARY INSURANCE INFORMATION (or check here for ❑ Cash Only)

Insurance Name:_____	Policy #:_____	Group #:_____
Insured is: ❑ Self ❑ Spouse* ❑ Parent* ❑ Other* _____ (*if not Self, please complete next two rows)		
Name of Insured:_____	Date of Birth:_____	
Soc. Sec. #:_____	Employer:_____	

SECONDARY INSURANCE INFORMATION

Insurance Name:_____	Policy #:_____	Group #:_____
Insured is: ❑ Self ❑ Spouse* ❑ Parent* ❑ Other* _____ (*if not Self, please complete next two rows)		
Name of Insured:_____	Date of Birth:_____	
Soc. Sec. #:_____	Employer:_____	

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurances and any other health plans to: Fox Valley Physician Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ Date_____

If Minor, Signature of Responsible Party: _____ Date_____

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Request for Confidential Communication

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I, _____, hereby request Fox Valley Physician Services, S.C.
(Print Patient's Name)
to keep all communications regarding my protected health information confidential. To accomplish this request, please adhere to the following requests:

PHONE

You may contact me by phone at the following numbers:

- ❑ Home Phone _____
- ❑ Mobile Phone _____
- ❑ Work Phone _____

You may leave messages on my answering machine: ❑ Yes ❑ No ❑ N/A

You may leave messages on my voice mail: ❑ Yes ❑ No ❑ N/A

You may leave messages with another person: ❑ Yes* ❑ No ❑ N/A

*If Yes, please provide names of approved people:_____

_____

MAIL

You may send mail to me at:

Address:_____

City:_____

State:_____

Zip:_____

EMAIL

You may send email to me at:

_____

FAX

You may send faxes to me at:

_____

Other Requests for Confidential Communications:_____

_____

_____

❑ I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Signature:_____ Date:_____

Date of Birth:_____

If you are not the patient, please specify your relationship to the patient:_____

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Pain Location Diagram

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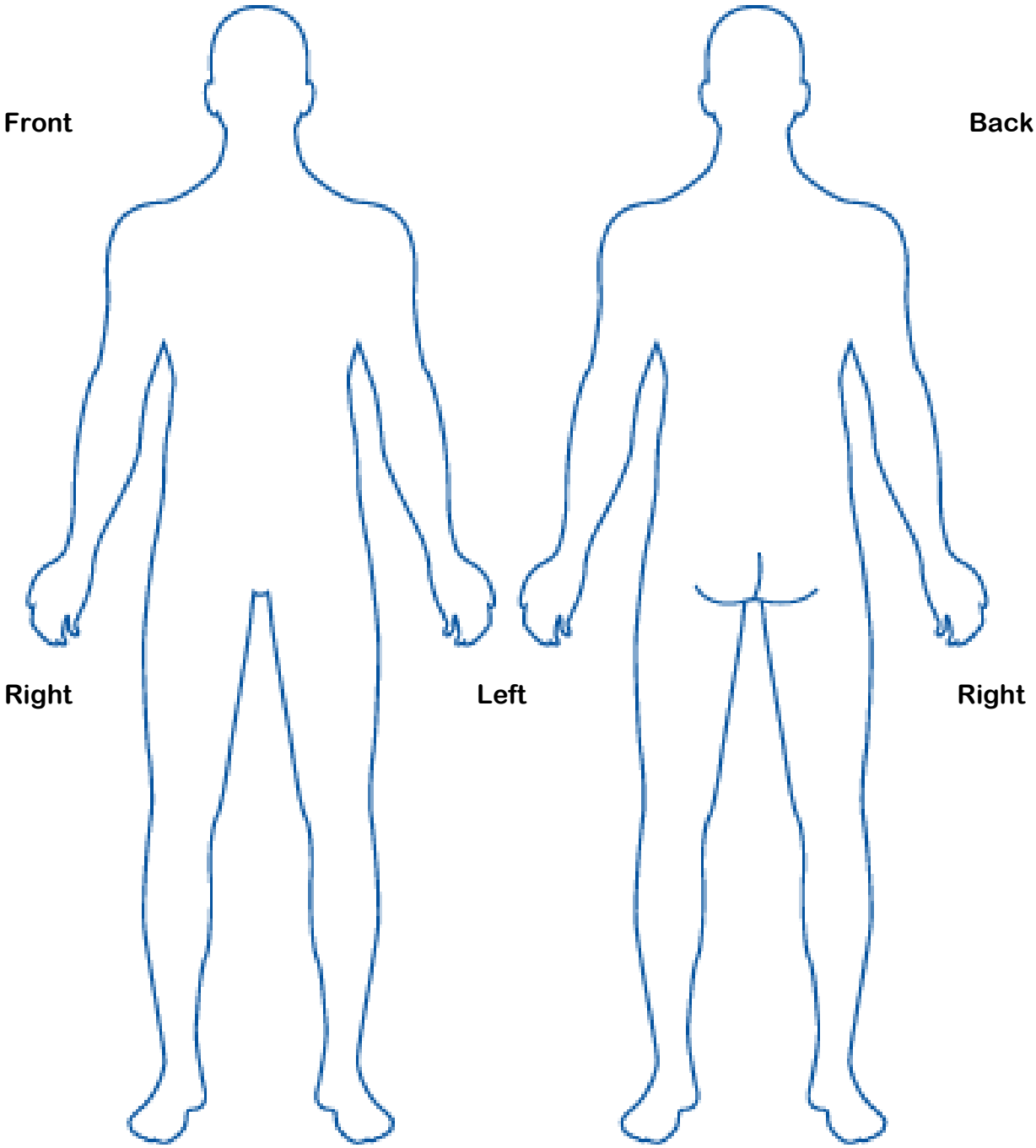
DIRECTIONS
Mark the most severe pain areas with “XXXXX”
Mark moderate pain areas with “OOOOO”



Patient Signature:_____ Date:_____

Symptom Checklist

Patient Name : _____ Date of Birth : ____/____/____

Patient Signature : _____ Today's Date : ____/____/____

Please indicate which of the following symptoms you experience:

Symptom	Side of the Body			
Back and Leg Pain	Right	Left	Both	None
Pain in your lower back	☐	☐	☐	☐
Pain in your buttocks	☐	☐	☐	☐
Pain or burning in your legs	☐	☐	☐	☐
Numbness or tingling in your legs	☐	☐	☐	☐
Weakness in your legs	☐	☐	☐	☐
Loss of strength in your legs	☐	☐	☐	☐
Foot Pain	Right	Left	Both	None
Pain or burning in your feet	☐	☐	☐	☐
Numbness or tingling in your feet	☐	☐	☐	☐
Feels like pins and needles in your feet	☐	☐	☐	☐
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	☐	☐	☐	☐
Trouble feeling hot or cold in your feet	☐	☐	☐	☐
Trouble feeling your feet when you walk	☐	☐	☐	☐
Discomfort or pain at night in your feet	☐	☐	☐	☐
Hand, Finger or Wrist Pain	Right	Left	Both	None
Pain or burning in your fingers	☐	☐	☐	☐
Numbness or tingling in your fingers	☐	☐	☐	☐
Difficulty gripping things with your hands	☐	☐	☐	☐
Difficulty forming a fist with your hands	☐	☐	☐	☐
Discomfort in hands wakes you at night	☐	☐	☐	☐

Diabetes Mellitus

Do you have diabetes? ☐ Type 1 ☐ Type 2 ☐ No

How long have you had diabetes? _____

Office Use Only

Clinical Assessment

Confirmed : ☐ Yes ☐ No

Exam Notes :

Confirmed : ☐ Yes ☐ No

Exam Notes :

Confirmed : ☐ Yes ☐ No

Exam Notes :

Eye Exam Notes :

Clinician Use Only

Date of last documented dilated eye exam ____/____/____ ☐ None

Clinician Review _____

Schedule RIS Date _____

Schedule NCS Date _____

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MEDICAL HISTORY

Pneumonia	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Polio	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Whooping Cough	❑ Yes ❑ No	GI Problems	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Measles	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Mumps	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Small Pox	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chicken Pox	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Lumbago	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Eczema	❑ Yes ❑ No	Autoimmune Disease	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Heart Attack	❑ Yes ❑ No	Bleeding Problems	❑ Yes ❑ No

Surgeries:_____

_____

Date of Last Physical Exam:_____

Other Significant Conditions? ❑ Yes ❑ No

If Yes Describe: _____

_____

SOCIAL HISTORY

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Engaged ❑ In a Relationship

Children: Sons? ❑ Yes ❑ No Ages:_____

Daughters? ❑ Yes ❑ No Ages:_____

Work Status: ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Student ❑ Homemaker

Nutritional Habits: _____

_____

Exercise (How Much? How Often? What Type?):_____

_____

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Patient History

Name:_____ Date of Birth:_____

SOCIAL HISTORY (Cont.)

Smoking: ❑ Non-smoker ❑ Former Smoker ❑ Smoker

Would you like to quit? ❑ Yes ❑ No

Years of smoking _____ Packs per day _____

Alcohol: Do you drink alcohol? ❑ Yes ❑ No

How many drinks per day? _____

Illicit drug use? ❑ Yes ❑ No

If Yes, please describe_____

Difficulty Sleeping? ❑ Yes ❑ No

Snoring? ❑ Yes ❑ No

Daytime Drowsiness? ❑ Yes ❑ No

FAMILY HISTORY

Please indicate with an 'X' which family members have experienced the following health issues:

					Maternal		Paternal	
	Mother	Father	Sister	Brother	Grandmother	Grandfather	Grandmother	Grandfather
Hypertension								
Hyperlipidemia								
Coronary heart disease								
Diabetes mellitus,Type 1								
Diabetes mellitus,Type 2								
COPD								
Thyroid disease								
Breast cancer								
Other cancer								
Colorectal cancer								
Alcoholism								
Depression								
Other mental illness								
Other:_____								

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Patient Rights and Responsibilities

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Fox Valley Physician Services (FVPS) is committed to providing accessible, quality health care to all patients that come to the FVPS clinic for treatment and other health care needs. Our goal is to ensure that staff treats each person with dignity, respect and that each patient understands their rights and responsibilities.

PATIENT RIGHTS

1. Know that all information in your chart or records will be treated in a confidential way by all staff of FVPS unless you have given permission for the release of your medical information or reporting is required or permitted law. The staff includes full-time, part-time, temporary or volunteer staff and consists of nurses, physicians, billing, and administrative personnel.

2. Know at all times that you can register complaints or discuss concerns with our Office Manager.

3. Know that you will not be excluded from receiving services based on the grounds of sex, sexual orientation, national origin, race, religion, ethnicity or economic status.

4. Know that you have the right to be free from mental and physical abuse and that your civil rights will be respected.

5. Know that you have the right to discuss with your provider all decisions regarding the furnishing of care, denial or changes in service. If you are ineligible for services, a written record of your concerns and the reason for the decision will be placed in your records by your provider.

6. Know you will receive open and honest communication from your provider.

PATIENT RESPONSIBILITIES

1. To maintain open and honest communication with your provider at all times.

2. To keep all scheduled appointments or cancel by calling Fox Valley Physician Services at (630) 966-2637 to reschedule no less than twenty-four hours in advance. Failure to provide at least twenty-four hour notice will result in a $25.00 “no show” fee for regular standard appointments ($100 no show fee will apply to all cancelled procedure appointments without twenty-four hour notice) and the fee is to be paid prior to your next appointment.

3. To strictly adhere to your medications schedule as prescribed by your provider. Please note that refill scripts will only be written in person at the time of your appointment with the doctor and will not be granted prior to your preset refill date regardless of your specific circumstance. (Faxed requests from the pharmacy will not be refilled unless prior arrangements have been made with your provider)

4. To inform your provider of any significant changes in your condition: Physical, social, etc.

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PATIENT RESPONSIBILITIES (Cont.)

5. To actively participate in your treatment plan, being careful to follow the doctor's prescribed orders and asking questions to clarify expectations. You should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side effects, complications, or worsening of the condition occur, you should notify your providers promptly. In addition, you should also inform your providers of other medications and treatments you are pursuing simultaneously with other medical providers.

6. As many treatment plans are scheduled in advance, please understand your condition will not progress as expected if you are missing appointments or treatments. If you feel that you need to discontinue care at FVPS for any reason, please discuss this with the Doctors so that a discharge from care order may be given.

7. To become knowledgeable about your health plan. You should read and become familiar with the terms, coverage provisions, rules, and restrictions of your health plans. You should not be hesitant to inquire with appropriate sources when additional information or clarification is needed about these matters.

8. To maintain your financial obligations with Fox Valley Physician Services as agreed. Payment for services rendered will be required prior to your scheduled appointment. This includes co-payments, cash payments, and all other financial arrangements that have been mutually agreed upon by you and an approved member of the Fox Valley Physician Services financial staff.

9. To pursue healthy lifestyles. You should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, you should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.

10. To honor the Doctor's time by limiting your questions for the Medical staff to the time of your appointment. (This includes but is not limited to refill requests) With the office functioning in an open concept setting, while the doctor may be visible, he may not be available for additional questions. Honoring the Doctors time will insure our ability to function in an efficient and effective manner at all times.

MUTUAL RESPECT AND COOPERATION WILL ENSURE A PRODUCTIVE RELATIONSHIP

_____ _____
Patient Signature Date

_____
Print Name

_____ _____
FVPS Representative Date