Surgeons of Northern Illinois
20 Tower Court, Suite A
Gurnee IL 60031
847-244-3525

Thank you very much for contacting our office and scheduling an appointment. Enclosed please find your paperwork, which needs to be completed prior to your scheduled appointment time.
Please complete the enclosed paperwork and bring with you to your scheduled appointment.

Your appointment is scheduled for: _____

20 Tower Court, Ste A
Gurnee IL 60031

If you have any further questions, please feel free to contact me at your convenience.

Sincerely,

Maria

Michael F. Scheer, M.D., F.A.C.S. Daniel A. Liesen, M.D., F.A.C.S. Amit Parikh, D.O., F.A.C.O.S.

Thank you for selecting our healthcare Team! We will strive to provide you with the best possible care.
To help us meet all your healthcare needs, please fill out this form completely.
Your Driver's License and Social Security number is required in order to determine identity. It is the policy of our practice to implement an Identity Theft Prevention Program to detect, prevent and mitigate identity theft in connection with new and existing patient accounts.

Drivers License # _____

Patient Information *(CONFIDENTIAL)*

Soc. Security # _____

Last Name _____ *First Name* _____ *MI* _____
Address _____ *City* _____ *State* _____ *Zip Code* _____
Date of Birth _____ *Sex* _____ ***Phone#*** _____ *Marital Status* _____
Race: _____ *Language Preference:* _____
Pharmacy Preference and Location: _____
Occupation _____ ***Cell Phone #*** _____ *Email:* _____
Patient's Employer _____ *Work #* _____
Work Address _____ *City, State, Zip* _____
Spouse or Parent's Name _____ *Employer* _____ *Work #* _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency:
_____ *Phone #* _____ *Relationship:* _____

Name of Family Physician _____

Insured Information

Relationship to
Name of insured _____ *Patient* _____
Address _____ *Phone#* _____
City _____ *State* _____ *Zip Code* _____
Birthdate _____ *Soc. Sec. #* _____ *Work #* _____
Employer _____

Primary Insurance

HMO ____ *PPO* _____ *POS* _____ *Workman's Comp* ____ ***Co-pay amt.$*** _____
Insurance Company _____ *Group #* _____
Policy / I.D. # _____ *Phone #* _____
Address _____ *City* _____ *State* _____ *Zip* _____
If Workers Compensation: *Date of Injury* _____ *Contact Person:* _____
Phone # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO If yes, complete the following
Name of Insured _____ *Relationship to Patient* _____
Birthdate _____ *Soc. Sec. #* _____ *Employer* _____
Insurance Company _____ *Group #* _____
Policy / I.D. # _____ *Phone #* _____
Address _____ *City* _____ *State* _____ *Zip* _____

Financial Arrangements: *For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected at the time of service unless other arrangements have been made with our office.*
_____ ***Cash*** _____ ***Personal Check*** _____ ***Visa*** _____ ***MasterCard***

Authorization and Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize you to release and to receive any medical information to those you deem necessary. I hereby authorize my insurance company to pay directly to Surgeons of Northern Illinois benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____/_____
Signature of patient or parent if minor Date

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FINANCIAL POLICY

The following is our financial policies, which we require you to read and sign prior to any treatment. As a courtesy to you, we will bill your insurance company if we are given necessary forms and information at the time of your initial service. All patients must complete our Patient Registration Form in full prior to being seen by any provider at Scheer and Liesen Surgical Associates.

All patient/guarantors are responsible for payment at the time of service of all co-payments, deductibles or co-insurance unless prior arrangements have been made.

We accept Cash, Check, MasterCard, Visa and Discover. You will be charged a $35.00 bank fee for any returned checks for any reason.

Insurance Co-payments

Insurance co-payments are paid at the time of service.

Deductible/Co-Insurance

If your insurance deductible is not met, full payment will be collected at the time of service. If your insurance deductible is met, your co-insurance amount will be collected at the time of service. Your insurance is a contract between you (the Subscriber), your employer and the insurance company. We are not a party to that contract. Should your insurance fail to pay, for any reason, you are responsible for the balance. We will transfer liability of the claim to you if your insurance does not properly pay within 45 days. Scheer and Liesen Surgical Associates expects you to be interactive and responsible for communicating with your insurance carrier on any open claims

Private Pay

If you have no insurance coverage or have insurance that we do not participate with, full payment is expected at the time of service unless prior arrangements have been made with our office.

Bariatric Procedures

We will contact your insurance company regarding eligibility and benefits and notify you with an estimated out of pocket cost that will be your responsibility. A $250.00 deposit is required prior to surgery which will be applied towards your account.

Collections

Once an account is placed in collections status, all future services must be paid in full at the time of service. Any balance assigned to our collection agency will be assessed a 40% fee, to offset the recovery expense.

I have read and agree to abide by this financial policy.

_____

(Signature) ***(Date)***

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND 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 that treatment directly and indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that Surgeons of Northern Illinois has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____, hereby request Surgeons of Northern Illinois to keep communication regarding my Protected Health Information confidential. To accomplish this request, please adhere to the following requests:

Communication Preference(s): ___Letter ___Cell ___Home ___Work

Phone: You can contact me by phone at _____ or _____
Leave messages on answering machine: ☐ Yes ☐ No

Can we send you e-mail reminders on appointments or account balances? ___Yes ___No
E-mail: You can contact me via e-mail @ _____

You may discuss my Protected Health Information with the following individuals:
Name _____Relationship_____ Phone #_____
Name _____Relationship_____ Phone #_____
Name _____Relationship_____ Phone #_____

Other requests for Confidential Communications: _____

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

Surgeons of Northern Illinois

Welcome to our practice. As a new or existing patient presenting with a new problem, please fill out the information to the best of your ability.

ACCT #_____

PATIENT NAME: _____ **DATE OF BIRTH: _____Age: _____**

Office Use Only

Temp _____ BP _____ / _____ Pulse _____ Height _____ Weight _____ Taken by: _____

HISTORY OF PRESENT ILLNESS:

Where is the pain/problem? _____

How severe is the pain/problem on a scale of 1-5 with 5 being the most severe? 1 2 3 4 5 (please circle your choice)

Does the pain/problem occur at a specific time? _____

What makes the pain/problem worse or better? _____

Referring Physician: _____

Past Medical History: Have you ever had the following: (Please √ all that apply)

Acid Reflux	O	Blood Clots	O	Heart Disease	O	Migraine Headaches	O
AIDS or HIV +	O	Bronchitis/COPD	O	Hemorrhoids	O	Mitral Valve Prolapse	O
Anemia	O	Cancer	O	Hernia	O	Pneumonia	O
Arthritis	O	Chickenpox	O	Hepatitis	O	Rheumatic Fever	O
Asthma	O	Depression	O	High Blood Pressure	O	Sleep Apnea	O
Bladder Infection	O	Diabetes	O	High Cholesterol	O	Thyroid Disease	O
Back Trouble	O	Epilepsy/Seizures	O	Hives or Eczema	O	Tuberculosis	O
Bleeding Tendency	O	Glaucoma	O	Kidney Disease	O	Venereal Disease	O

Are you on any blood thinners?: Yes **O** No **O** (If yes, please list) _____

Can you walk up a flight of stairs without stopping? Yes **O** NO **O**

Prior Surgeries/Hospitalizations/Diseases		**When?**	**Hospital, City. State**
None	**O**		
Appendix (appendectomy)	**O**	_____	_____
Gallbladder (cholecystectomy)	**O**	_____	_____
Uterus (hysterectomy)	**O**	_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

Medications: None **O**

	Please list dosage and frequency	Please list over-the-counter medications, Vitamins, Herbal supplements, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY KNOWN DRUG ALLERGIES: None **O**

_____ **Reaction:** _____

_____ **Reaction:** _____

_____ **Reaction:** _____

Patient Social History:

Occupation: _____

Marital status: Single:___ Married:___ Separated:___ Divorced:___ Widowed:___

Use of alcohol: Never:___ Rarely:___ Moderate:___ Daily:___

Use of tobacco: Never:___ Previously, but quit:___ Current packs / day:_____, Approximate duration_____

Do you use street drugs? ____ Yes ____ No

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____
	___	_____	_____

PATIENT NAME: _____

Review of Systems: Please indicate any personal history below:

CONSTITUTIONAL SYMPTOMS
- Good general health lately O
- Recent weight gain O
- Recent weight loss O
- Fatigue O
- Fever O

EYES
- Eye disease or injury O
- Wear glasses/contact lenses O
- Blurred or double vision O

EARS/NOSE/MOUTH/THROAT
- Mouth sores O
- Bleeding gums O
- Hearing loss or ringing O
- Chronic sinus problem O
- Nose bleeds O
- Sore throat or voice change O
- Swollen glands in neck O

CARDIOVASCULAR
- Abnormal EKG O
- Heart trouble O
- Chest pain angina pectoris O
- Palpitation O
- Shortness of breath w/ walking or lying flat O
- Swelling of feet, ankles or hands O
- Heart murmur O

RESPIRATORY
- Chronic or frequent coughs O
- Spitting up blood O
- Shortness of breath O
- Wheezing O
- Tuberculosis O
- Asthma O
- Emphysema O

GASTROINTESTINAL
- Loss of appetite O
- Change in bowel movement O
- Nausea or vomiting O
- Frequent diarrhea O
- Painful bowel movements O
- Gallbladder problems O
- Rectal bleeding O
- Blood in stool O
- Hemorrhoids O
- Abdominal pain O
- Gastric Reflux O

GENITOURINARY
- Frequent urination O
- Burning or painful urination O
- Blood in urine O
- Change in force of stream when urinating O
- Incontinence or dribbling O
- Kidney stones O
- Sexual difficulty O
- Male – testicle pain O
- Female – pain with periods O
- Female – irregular periods O
- Female – vaginal discharge O
- Female - # of pregnancies _____
- Female - # of miscarriages _____
- Female – date of last pap smear _____
- Date of last menstrual period _____

MUSCULOSKELETAL
- Joint pain or stiffness O
- Difficulty in walking O
- Muscle weakness O
- Muscle pain or cramps O
- Back pain O
- Cold extremities O

INTEGUMENTARY (skin)
- Rash or itching O
- Change in skin color O
- Change in hair or nails O
- Varicose veins O

BREAST
- Breast pain O
- Breast lump O
- Nipple discharge O
- Date of last mammogram _____
- Date of Breast Biopsy _____
- Breast Rash O

NEUROLOGICAL
- Head injury O
- Light headed or dizzy O
- Convulsions or seizures O
- Numbness or tingling sensations O
- Stroke or mini-stroke O
- Tremors O
- Paralysis O
- Headaches O

PSYCHIATRIC
- Memory loss or confusion O
- Nervousness O
- Depression O
- Insomnia O
- Suicidal thoughts O
- Violent or Unusual thoughts O

ENDOCRINE
- Glandular or hormone prob O
- Excessive thirst or urination O
- Heat or cold intolerance O
- Skin becoming drier O
- Thyroid problems or goiter O

HEMATOLOGIC/LYMPHATIC
- Enlarged glands O
- Slow to heal after cuts O
- Bleeding or bruising tendency O
- Anemia O
- Phlebitis/Blood clots O

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
- Penicillin O
- Other Antibiotics _____ O
- Novocain O
- Other Anesthetics _____ O
- Aspirin O
- Other pain remedies _____ O
- Iodine O
- Morphine O
- Demerol O
- Other narcotics _____ O

Known food Allergies: _____

_____

Anesthesia problems: _____

_____

Environmental allergies: _____

_____

LATEX ALLERGY O

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 health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient or Guardian_____ Date: _____

Signature of Doctor_____ Date: _____