Welcome to Advocate Medical Group
Patient Registration

Advocate Medical Group®

PRIMARY PHYSICIAN NAME (LAST, FIRST) AND OFFICE LOCATION (CITY) | DATE

Patient Information *(please print)*

PATIENT NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | GENDER M F

ADDRESS & UNIT NUMBER IF APPL. | CITY, STATE, ZIP CODE

MOBILE (CELL) | CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION? YES NO | OTHER PHONE NUMBER | CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION? YES NO

EMAIL ADDRESS (USED FOR PORTAL ACCOUNT/COMMUNICATION) | MARITAL STATUS

PREFERRED LANGUAGE | RACE (Optional) | ETHNICITY (Optional)

Account Guarantor if not the patient

GUARANTOR OF ACCOUNT (FINANCIALLY RESPONSIBLE PARTY)

NAME:_____ ADDRESS: _____ APT. / SUITE: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

Primary and Secondary Insurance with Subscriber Info (attach a copy of both sides of insurance cards)

	Primary Insurance	Secondary Insurance
Insurance Name		
Insurance Address		
Insurance City/State/Zip		
Group Number		
Policy Number		
Effective Date		
Subscriber's Name		
Subscriber's Date of Birth		
Relationship to Patient		

Emergency Contact

EMERGENCY CONTACT NAME (LAST, FIRST) | RELATIONSHIP TO PATIENT

CELL PHONE NUMBER | HOME PHONE NUMBER | WORK PHONE NUMBER

I authorize Advocate Medical Group to disclose my Patient Health Information to the following person(s)

NAME:_____ PHONE NUMBER:_____ RELATIONSHIP: _____

NAME:_____ PHONE NUMBER:_____ RELATIONSHIP: _____

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Advocate Medical Group and its agents to release any medical or incidental information that may be necessary for either medical care, to submit a health insurance claim, in processing applications for financial benefit, for quality assurance, or for Advocate Medical Group review for the purpose of medical research.

APPLICABLE TO MEDICARE PATIENTS:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment of surgical/medical benefits to Advocate Medical Group for services rendered. I understand that I am financially responsible to Advocate Medical Group for charges not covered by this assignment. In some cases, your provider's fee is not covered in full by your insurance company. This balance due includes provisions set by your insurance company such as copayments, deductibles, and "usual and customary" allowance.

GUARANTEE OF PAYMENT:
In consideration of all medical services given by Advocate Medical Group to the patient named above, I agree to pay to Advocate Medical Group all fees and charges made for services, which may include the cost of collection and/or reasonable attorney's fees. Payment is due and payable within 30 days of billing date. A late charge may be added to the account for all charges not paid within 90 days.

I hereby certify that the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of these agreements as set forth. A photocopy of this form shall be valid as the original. I understand that it is my responsibility to notify Advocate Medical Group of any changes to the above information.

SERVICE CHARGE: A $25.00 SERVICE CHARGE PER RETURNED CHECK WILL BE ASSESSED

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ DATE: _____

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY: _____

Our Notice of Privacy Practices ("**Notice**") provides information about: (1) the privacy rights of our patients; and (2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **AHC-CorporateHIPAA@advocatehealth.com** or a letter to:

Chief Privacy Officer
Advocate Health Care
3075 Highland Parkway
Suite 600
Downers Grove, IL 60515

Phone: (630) 929-5922

By signing this form, you are only acknowledging that you have been provided our Notice.

Signature of Patient or Authorized Representative	Date of Signature
Print Name of Patient/Authorized Representative	Date of Birth of the Patient or Medical Record Number
Signature of Parent/Legal Guardian/Legal Representative	Date of Signature
Parent/Legal Guardian/Legal Representative Printed Name	Relationship to Patient

00406 5

Advocate Health Care

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Patient Label

Advocate Medical Group
Inspiring medicine. Changing lives.

AMG Orthopedics

Legal Name:(First) (Middle) (Last) **Date of Birth** **Today's Date**

Is this a WORKMAN"S COMP CASE? ☐**Yes** ☐**No**
Is legal action / litigation pending due to this injury? ☐**Yes** ☐**No**

Height _____ Weight _____lbs. ☐Rt. Handed ☐Lt. Handed

REFERRED BY:				
☐ER/Acute Care Center	☐Family	☐Self	☐Insurance Network	☐Friend
☐PCP:	☐Community Event	☐School:	☐Internet	☐Other:

PREFERRED PHARMACY	**PRIMARY CARE PHYSICIAN**
Name: Phone:	Name: Phone:
Address:	Address:

HISTORY OF PRESENT ILLNESS:

(Reason for today's visit, describe what happened):

☐Work injury ☐Fall ☐Sports injury ☐Car accident ☐Other:

_____

_____

DATE of onset/Injury: _____ **Symptoms:** _____

LOCATION of symptoms: _____ ☐**Right** ☐**Left** ☐**Both** ☐ **NA**

Check all that apply:

Level of Pain:(Least = 0; Greatest = 10) **(Circle one)** 0 1 2 3 4 5 6 7 8 9 10

Pain Quality: ☐Sharp ☐Throbbing ☐Dull ☐Aching ☐ Burning ☐Cramping

Symptoms worsen with: ☐ Activity ☐Walking ☐ Running ☐Stairs ☐Squatting ☐Pivoting
☐Overhead use ☐Throwing ☐Lifting ☐Other_____

Symptoms improve with: ☐ Rest ☐Heat ☐Cold ☐Elevation ☐ Physical Therapy
☐Brace ☐Injection ☐Medication ☐None ☐Other_____

PREVIOUS TREATMENT/THERAPY:

☐PT ☐OT Other: _____

Diagnostic tests for this problem? ☐ X-Ray ☐ MRI ☐ US ☐CT ☐ Other: _____

Test Location: _____ Date: _____

A physician recommended surgery ☐ Yes ☐ No

Name of previous treating physician(s), if applicable: _____

Advocate Medical Group
Inspiring medicine. Changing lives.

AMG Orthopedics

SOCIAL HISTORY

☐**Student** School: _____ Grade: _____ Sport: _____

☐ **Currently employed**? ☐ Disabled ☐ Retired from: _____Occupation: _____

☐**History of Smoking** ☐Quit Smoking age____ ☐Current Smoker Packs per day: _____

Alcohol Use: ☐Never ☐Monthly ☐Weekly ☐Daily **Are you Pregnant: ☐ Yes ☐ No**

Past Surgical History		
Procedure:	Surgeon:	Date:
Procedure:	Surgeon:	Date:
Procedure:	Surgeon:	Date:

☐ **History of Anesthesia** ☐**Problems with anesthesia**: Describe:_____

Past Medical and family History

Has there been a recent change to your health? ☐NO ☐YES:_____

	Self	Family
Eyes (e.g. blurred vision, double vision, loss of vision)	☐	☐
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	☐	☐
Cardiovascular (chest pain, palpitations, ankle swelling)	☐	☐
Respiratory (e.g. shortness of breath, cough, snore)	☐	☐
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	☐	☐
Genitourinary(e.g. burning, bleeding or difficulty urinating)	☐	☐
Musculoskeletal (e.g. joint. muscle, back or neck pain)	☐	☐
Skin {e.g. delayed healing, rash, acne, cellulitis, psoriasis)	☐	☐
Neurological (e.g. numbness, tingling, weakness)	☐	☐
Psychiatric (e.g. depression, anxiety, memory loss)	☐	☐
Endocrine(e.g. weight gain/loss, excess thirst or urination)	☐	☐
Hematologic (e.g. bruising, bleeding or clotting disorder)	☐	☐
Diabetes Mellitus	☐	☐
Other Significant history:	☐	☐

Medications (Prescription/Over-the-Counter/ Herbal Supplements /Vitamins/Other)	**Dosage**	**How Long?**

ALLERGIES:

☐Medication: Reaction:	☐Latex Reaction:	☐Other Reaction:

Patient/Guardian Statement: To the best of my knowledge, the above information is accurate and complete.

_____

PATIENT PRINTED NAME DATE TIME PATIENT SIGNATURE

_____

Guardian/Authorized Representative PRINTED NAME DATE TIME SIGNATURE