

Patient Information Sheet

Today's Date: _____

First Name _____ Middle Initial _____ Last Name _____ Sex: ☐ M ☐ F ☐ Other

Date of Birth _____ SS# _____ INS: Primary _____ Secondary _____

Address _____ City _____ State _____ Zip Code _____

Home phone: _____ Cell phone: _____ E-mail address: _____

Marital Status: ☐ Single ☐ Married ☐ Other: _____ Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Other: _____

Ethnicity: (Check One) Non-Hispanic _____ Hispanic _____ Other _____ Refused to Report _____

Primary Race: (Check One) White _____ Hispanic _____ African _____ Asian _____ Native American _____ Native Hawaiian _____

Other _____ Pacific Islander _____ Other Race _____ Unreported/Refused _____

Preferred Language: English _____ Spanish _____ Other _____

Do you have any advanced directive such as a living will or medical power of attorney? Yes _____ No _____

Primary Care Physician

Name: _____ Phone #: _____ Address: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Do we have permission to contact this person concerning your care? Yes _____ No _____

Pharmacy

#1 Preferred Pharmacy Name: _____ Address: _____ Mail Order? Yes _____ No _____

Phone Number: _____ Fax # _____

#2 Preferred Pharmacy Name: _____ Address: _____ Mail Order? Yes _____ No _____

Phone Number: _____ Fax # _____

Electronic Prescriptions: Our electronic medical record program accesses your prescription/medication history in order for us to safely to prescribe your medication. By signing this you authorize us to do so.

Immunizations: Our electronic medical record program allows for your immunization data to be sent directly to the I-Care State of Illinois Registry. I-Care allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have change in health.

I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Respiratory, Critical Care and Sleep Specialist, LLC all insurance benefits, if and otherwise payable to me for services rendered. I the Respiratory Critical Care and Sleep Specialist LLC to release all information necessary to secure the payment of benefits I authorize the use of the signature on all insurance submissions.

Signature: _____ Date: _____

Health Information Sheet

Respiratory, Critical Care & Sleep Specialists

1400 E Golf Rd, Suite 211, Des Plaines, IL 60016 P) 847-376-8969

5600 W Addison St, Suite 503, Chicago, IL 60634 P) 773-283-8664

5999 New Wilke Rd, Bld 1 Suite 107, Rolling Meadows, IL 60008 P) 224-225-4959

F) 773-283-8688

Allergies _____

Current Medications

Name of Medication	Dose	Frequency

Name of Medication	Dose	Frequency

Surgeries

Surgery	Date

Family Medical History (select all that apply)

Father: ☐Deceased ☐Diabetes ☐Hypertension ☐Heart Disease ☐Cancer- if yes, type_____

Mother: ☐Deceased ☐Diabetes ☐Hypertension ☐Heart Disease ☐Cancer- if yes, type_____

Sibling(s): ☐Deceased ☐Diabetes ☐Hypertension ☐Heart Disease ☐Cancer- if yes, type_____

Children: ☐Deceased ☐Diabetes ☐Hypertension ☐Heart Disease ☐Cancer- if yes, type_____

Health Questionnaire

Are you currently experiencing any of the following? (select all that apply)

☐Body Chills ☐Fatigue ☐Night Sweats ☐Diabetes ☐Cough ☐Dyspnea on Exertion ☐Chest Pain

☐Constipation ☐Diarrhea ☐Difficulty Swallowing ☐Anemia ☐Abdominal Pain ☐Discomfort Urinating

☐Blood in Urine ☐Back Pain ☐Dizziness ☐Decreased Appetite ☐Depression

Name: _____

Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the physician notice of privacy practices detailed information about how the practice may use and disclose any confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice, I also understand that a copy of revised notice will be provided to me or made available.

Insurance Authorization and Assignment

I authorize release of medical information to process any insurance claims and I authorize payment of medical benefits directly to Respiratory, Critical Care and Sleep Specialist LLC and the Physician of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurance, co-pays or amount for services not covered by the insurance.

Release of Information and Test Results

I authorize Respiratory, Critical Care and Sleep Specialist LLC and the Physician the release of medical information and/or test results to help aid the diagnosis and treatment of any problem which the physician feels needed.

Consent of Treatment and/or Testing

I authorize the physician to administer treatment and medication as deemed necessary or advisable by the physician for myself and/or dependent.

Appointment Cancellation/No Show Policy

Effective October 1, 2021, any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "no show" and charged a \$40 fee. If a third No Show or cancellation/reschedule with no 24 hour notice should occur, the patient may be dismissed from Respiratory, Critical Care & Sleep Specialists. The fee is charged to the patient, not the insurance company, and is due by the time of the patient's next office visit. As a courtesy, when time allows, we make reminder call to all patients 2-3 days prior to their scheduled appointment. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

I have read and understand the above policies and agree to their terms.

Signature: _____ Date: _____