TODAY'S DATE ______________________________

FIRST NAME ___________________________ LAST NAME ____________________________________

ADDRESS ____ APT/UNIT _______

CITY ___________________________________ STATE __________ ZIP _________________________

HOME PHONE ______________________________ CELL ____________________________________

EMAIL ____BIRTHDATE __________________

SOCIAL SECURITY # __________/__________/_________ AGE ____________ GENDER _______

OCCUPATION ___________________ EMPLOYER________________WORK # _________________

WORK ADDRESS ____________________________ CITY/STATE/ZIP ___________________________

NICK NAME _______________________________ MARITAL STATUS (CIRCLE ONE) S M D W

SPOUSES NAME ____________________________________ BIRTHDATE ____________________

HOW DID YOU HEAR ABOUT US? ____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _________________________ PH#___________________

HAVE YOU EVER HAD CHIROPRACTIC/PHYSICAL THERAPY CARE BEFORE? ______________________

IF YES, WHEN ___________________ WHERE? ____

IS THIS INJURY/ILLNESS WORK RELATED? _____ DID YOU REPORT IT? (CHECK ONE) ☐ YES ☐ NO

IS THIS INJURY/ILLNESS RELATED TO AN AUTOMOBILE ACCIDENT? (CHECK ONE) ☐YES ☐ NO

DATE OF ACCIDENT ____________________

Check any activities which aggravate your condition: (Check as many as needed)

☐Standing ☐ Walking ☐Sitting ☐Lying ☐ Bending ☐ Lifting ☐Twisting ☐ Coughing

☐Other_______

Have you ever had these symptoms before? ☐Y ☐N (Check one) If Yes, When:___________________

Have you seen another doctor for this? ☐Y ☐N (Check one) If Yes, Doctor's name:________________

ASSIGNMENT & INSTRUCTION FOR DIRECT PAYMENT TO THE DOCTOR

I understand & agree that health & accident insurance policies are an arrangement between the insurance & carrier & myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports & forms to assist me in making collection from the insurance company & that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand & agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due & payable. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS & BENEFITS UNDER THE POLICY. It is understood & agreed the amount paid the Doctor for x-rays, is for the examination only & the x-ray negatives will remain the property of this office.

Patient's Signature X ____ Date _____________

Guardian or Spouses' Signature Authorizing Care X _________________________________ Date ____________

NAME: ____

Purpose of your visit today? ____

History of Present Illness:
When did you first experience pain? _________________ how long have you felt pain? ______________________
How often to you experience pain? (Constantly, daily, once a week, once and month, occasionally)
Does the pain radiate to the arms or legs?_________if so, is the pain greater in the leg/arm or spine?
Is the pain increasing, decreasing, or not changing?____

Past Medical History:
Have you had any pain in this area in the past? ______
Describe any previous falls, slips, trips or motor vehicle accidents within the past 3-5 years? _________________
(Please include minor fender benders or bumps)____
Allergies (drug & food, please list all) ____

Medications: You're currently taking
1. __________________________**Reason**______________ 4.__________________________**Reason**______________
2. __________________________**Reason**______________ 5.__________________________**Reason**______________
3.___________________________**Reason**______________ 6.__________________________**Reason**______________

Review of Symptoms	**Y/N**
Do you have a Pacemaker?	
Have you had any recent loss of weight or unexpected fever or fatigue?	
Have you had and loss of vision or double vision?	
Do you have hearing or speech problems?	
Do you have dizzy spells, irregular heart beat or palpitations?	
Have you ever vomited blood?	
Do you have abdominal/stomach pain?	
Do you have nausea, vomiting or constipation?	
Do you experience discomfort in urination?	
Do you get up at night to urinate?	

Family History	**Y/N**
Heart Disease	
Diabetes	
Hypertension	
Arthritis	
Cancer	

Habits:
___ I smoke cigarettes or cigars _______________ a day.
___ I drink alcoholic beverages ________________ per week.

Functional Limitations: Prior & Current:
What is your occupation? ____

Do you do a lot of heavy lifting or a lot of bending at work? ____

FOR DOCTOR'S USE ONLY: OTHER COMPLAINTS

____
____
____
____
____

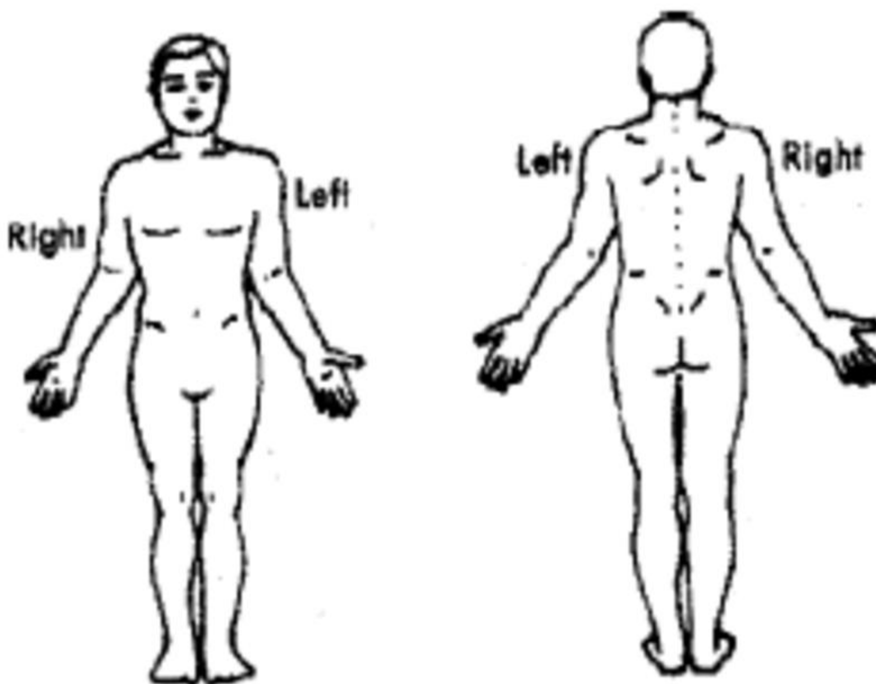
BODY PAIN SCALE

Pain Rating Scale: Use the number scale that is listed below to describe the INTENSITY of your pain.

NO PAIN	LOW	MEDIUM	HIGH	SEVERE
0	1 2 3	4 5 6	7 8 9	10

Using the number rating system above, describe your:

	Pain level NOW:		(0-10)
In the past 30 days	Pain level at BEST:		(0-10)
In the past 30 days	Pain level at WORST:		(0-10)



Use the symbols listed below to describe the location and type of pain or unusual feelings you are having by drawing them on the picture(s) above.

OOOO	Pins and Needles
XXXX	Numbness
//////	Pain
====	Other

Patient Signature: ____ Date: ____________
(Parent or Guardian if patient is a minor)

Rev 11/18/02

X-Ray Assignment Agreement

I understand that to assure the highest quality of interpretation of my X-rays, the services of a medical radiologist are being utilized. I also understand that the fees of this service will be submitted to my insurance carrier, workers compensation or attorney on the case of a personal injury. The following signature authorizes the release of medical information to:

Golf MRI
9680 Golf Road
Des Plaines, IL 60016

In the event that my insurance company sends me payment for these services, I agree to promptly remit such payment to North Suburban Physicians Group. I also understand that North Suburban Physicians Group will bill me for any unpaid amounts. I also understand that if I do not have insurance, I am responsible for the radiology fee.

I understand that these X-rays are property of North Suburban Physicians Group and that if I request to borrow my X-rays in order to take them out of the office to show to another doctor, I will be charged a deposit of $30 that will be held by North Suburban Physicians Group until such time that I return my x-rays or thirty days has passed at which time I forfeit the deposit.

Signature______________________
Date__________________________
Witness________________________

Pregnancy Release Form
(Females Only)

This is to certify that to the best of my knowledge, I am not pregnant and that North Suburban Physicians Group has my permission to take X-rays.

Signature______________________
Date__________________________
Witness_______________________

REG EXAM
N/C EXAM
C T L X-RAYS
OTHER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

North Suburban Physicians Group
8965 W. Golf Road
Niles, IL 60714-5812

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 nor mal health care 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 this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization 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: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________Initials:_________ Reason: ____________________________________

As a courtesy to our patients, we offer the following billing options. Please initial the one that applies to you and sign at the bottom of the page.

Private Pay

_______ I will pay for all services, as they are rendered, and submit my own insurance claim.

Group Health

_______ I would like to assign my benefits to your office and have you submit my insurance claims me. I will pay for initial services rendered and any co-payment for subsequent services. If my deductible has not been met, I will pay the full amount until it is met. I understand that if my insurance company does not pay the balance within 45 days of submission, I am responsible for the entire balance overdue.

Auto Accident/Personal Injury

_______ I was involved in an automobile accident/personal injury and would like to assign benefits to your office and have you submit all charges to my insurance company for me. I understand that the office will lien all parties involved. I also understand that regardless of settlement I am personally responsible for the entire balance. If for some unforeseen reason your office is not paid, I will personally pay the overdue balance.

Worker's Compensation

_______ I was involved in an injury at work. I will see to it that all appropriate paperwork is filed by my employer (i.e., accident report, etc.). I understand that it is my right as an Illinois citizen to have any bills incurred as a result of a work related accident paid for. In the event the worker's compensation denies your claim, we will bill your health insurance. I understand that if my health insurance company does not pay, I will be responsible for the entire balance.

Medicare

_______ I am a Medicare participant and will pay my coinsurance portion as services are rendered. I understand that your office does accept assignment of benefits for Medicare and will submit all charges to Medicare for me. I understand that Medicare does not cover all services and that I am responsible for the services that they do not cover.

Medicare Supplement

_______ I have a Medicare supplement and would like to assign benefits to your office for Part B Medicare.

PPO/Preferred Provider Organization (Blue Cross Blue Shield Only)

_______ I belong to a PPO that your office participates with. I understand that I am responsible for whatever co-payment, deductible, and non-covered services that my plan has set forth. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.

Maintenance Care

_______ I understand that maintenance care is not covered by most insurance companies. I will pay the maintenance fee as services are rendered and I understand that the insurance will not be billed.

I authorize the office to have the assignment of benefits to release any information to any insurance company, adjuster or attorney that will assist in the payment of a claim.

________________________________ ______________________

Patient/Responsible Party Signature Date

North Suburban Physicians Group 8965 W. Golf Rd Niles, IL 60714