LEGACY MEDICAL CARE

PATIENT INFORMATION

First Name: _____ Middle Initial: ___ Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Email: _____

Social Security: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Partner ☐ Other_____

Race: ☐ Asian ☐ African-American ☐ Caucasian ☐ Native Hawaiian ☐ American Indian ☐ Alaskan Indian ☐ Other Pacific Islander ☐ More than one race ☐ Choose not to disclose ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Choose not to disclose

Sex:☐ Male ☐ Female ☐ Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Choose not to disclose ☐ Other _____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't know ☐ Something else ☐ Choose not to disclose

Employer Name: _____ Address: _____ Phone: _____

PARENT / GUARDIAN INFORMATION

Mother's/Guardian's Name: _____ Birth Date: _____
Mother's/Guardian's Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Social Security: _____
Mother's/Guardian's Employer Name: _____ Employer Phone: _____
Employer Address: _____ City: _____ State:____ Zip: _____

Father's/Guardian's Name: _____ Birth Date: _____
Father's/Guardian's Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Social Security: _____
Father's/Guardian's Employer Name: _____ Employer Phone: _____
Employer Address: _____ City: _____ State:_____ Zip: _____

How you hear about us? ☐ Friend/ Family ☐ Advertisement ☐ Medical office ☐ School ☐ Other _____

Legacy Medical Care Inc. may call the phone number provided to remind you of your appointments, follow-ups, and when the patient is in need of an appointment. ☐ Yes ☐ No

Preferred Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Legacy Medical Care has consent to obtain prescription history. ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Names of individuals and relationship to the patient whom I give authorization to contact and give full medical information in case of an emergency.

Primary Emergency Contact: _____ Relationship to Patient: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Secondary Emergency Contact: _____ Relationship to Patient: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

PATIENT INSURANCE COVERAGE

Is the patient self-pay? □ Yes □ No

Primary Type of coverage: □ Medicaid □ Medicare □ PPO □ HMO

Patient Primary Insurance Name: _____ Effective Date: _____

Member ID Number: _____Group Number: _____Responsible Party: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Secondary Type of coverage:□ Medicaid □ Medicare □ PPO □ HMO

Patient Secondary Insurance Name: _____ Effective Date: _____

Member ID Number: _____Group Number: _____Responsible Party: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Household Income:

□ Less than $12,140 □ $12,141-$18,210 □$18,211-$24,280 □ More than $24,281 □ Don't Know

Number of household dependents: _____

Is the patient homeless? □ Yes □ No

I hereby assign, transfer, and set over to Legacy Medical Care Inc. all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by the insurance.

Parent/Guardian Signature: _____ Date: _____

Patient Signature: _____ Date: _____

LEGACY MEDICAL CARE

After Hours Care

If you have a medical problem that needs immediate attention, please call our clinics at any time of the day. If our clinics are closed, a provider will be paged immediately to help you.

Clinic Location:	Clinic Phone Number:
Addison OB/GYN:	(630) 705-1010
Addison Pediatrics and Family :	(630) 599-5400
Arlington Heights OB/GYN:	(847) 749-2248
Arlington Heights Pediatrics and Family:	(847) 749-2248
East Dundee:	(847) 844-3274
Elgin OB/GYN:	(847) 531-8430
Elgin Pediatrics and Family:	(847) 531-8430
Hanover Park OB/GYN:	(630) 705-1010
Hanover Park Pediatrics:	(630) 830-5926

The provider will ask you about your medical problem to decide if you need to:

- See a doctor immediately
- Go to an emergency room
- Stay at home and follow the provider's advice

Emergencies

If you or a family member has any of the following symptoms, immediately dial 911 or go to the nearest Emergency Room:

- Chest pain
- Coughing up or vomiting blood
- Difficulty breathing and/or shortness of breath
- Asthma attack
- Head injury, loss of consciousness, severe headaches
- Sudden confusion, weakness, dizziness, numbness, difficulty speaking
- Suicidal or homicidal behavior or thoughts
- Any other life threatening emergencies or serious injuries

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Legacy Medical Care Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____ and date of birth of _____

(Patient's Name)

I acknowledge receipt of the practice's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the practice has reserved a right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be posted in the office and a copy provided upon your request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the practice. I also understand that I will not be able to revoke this consent in cases where the practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the practice's office.

Signature: _____Date: _____

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

Consent for Medical Services

Patient Name _____ Date of Birth _____

I hereby consent for myself or my child to receive medical services from Legacy Medical Care Inc. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws.

I acknowledge that I have received information regarding the services, practices and hours of operation and that all of my questions have been answered to my satisfaction.

By signing below, I acknowledge that I have received a copy of, read and understood my rights and responsibilities.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Representative Signature Date

_____ _____

Staff Witness Signature Date

LEGACY MEDICAL CARE

Medical History

First Name: _____ Last Name: _____ Date of Birth: _____

Current Medications: (Include dose (amount) per day)

Medications	Dose	Frequency

Drug Allergies: ☐ Yes ☐ No
List:_____

Surgical History: ☐ Yes ☐ No

Date	Surgeries

Hospitalization: ☐ Yes ☐ No

Date Arrived	Discharged Date	Reason

Social History:
Do you smoke/use tobacco? ☐ Yes ☐ No If the answer is yes: How many packs a day? _____
Do you use tobacco using different method? ☐ Yes ☐ No If the answer is yes: How much a day? _____

Do you use drugs? ☐ Yes ☐ No If the answer is yes: What kind_____ How often? _____

Do you drink alcohol? ☐ Yes ☐ No If the answer is yes: How often? _____

Do you consume caffeine? ☐ Yes ☐ No If the answer is yes: How often? _____

Do you exercise? ☐ Yes ☐ No If the answer is yes: How often? _____

How much screen time a day do you have?_____ How often? _____

Have you ever been or are currently sexually active? ☐ Yes ☐ No

Birth Hospital (New Born patients only):
☐ Alexian Brothers Hospital ☐ Northwest Community Hospital ☐ Sherman Hospital ☐ St.Alexius Hospital

☐ Central DuPage Hospital ☐ Other: _____

Family History: Please mark an "X" to indicate the answer is yes.

	Living	Deceased	Unknown	Year of Birth		Asthma	Cancer	Diabetes	Heart Disease	Hypertension	Mental Illness	Migraine	Stroke	Unknown	Other
Daughter															
Son															
Spouse															
Mother															
Father															
Paternal Grand Father															
Paternal Grand Mother															
Maternal Grand Father															
Maternal Grand Mother															
Brother															
Sister															
Other:															
Other:															

GYN/ OB History (Please complete the following section if you are a Female)

What is the day of your last menstrual cycle? _____ At what age did you start your menstrual cycle? _____

Have you had a pap smear done? □ Yes □ No If the answer is yes: What is the date of your last pap smear? ___

How often do you get your period? _____ How many days is your period? _____

Are you on birth control? □ Yes □ No If the answer is yes what kind? _____

Have you had a mammogram? □ Yes □ No If the answer is yes what is the date? _____

Pregnancy History (All pregnancies) □ **Have never been pregnant**

Obstetrical history including abortions & ectopic pregnancies

					Child Information		
Year	**Place of delivery or Abortion**	**Duration Preg. (Wks)**	**Type of Delivery**	**Complications Mother and/or Infant**	**Sex**	**Birth Weight**	**Present Health**