Beverly Knigge FNP-BC

1 S. 161 Summit Avenue • Oakbrook Terrace, IL 60181 • **630.785.3610** • oakbrookmedical.com

Date: _____ Social Security Number: _____

Patient Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Preferred method of contact (for appointment reminders): ❑ Phone ❑ Email

Sex: ❑ Male ❑ Female Birthdate: _____ Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Patient employed by: _____

Address: _____

Business Phone: _____ Occupation: _____

Person responsible for payment:

Name: _____ Birthdate: _____

Relationship to patient: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

In case of emergency, who should we notify?

Name (relationship): _____ Phone: _____

Do you have medical insurance? ❑ Yes ❑ No If yes, please be prepared to present your insurance card.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Beverly Knigge FNP-BC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Beverly Knigge FNP-BC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature or Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Beverly Knigge FNP-BC for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

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PATIENT INFORMATION

Date: _____

Name: _____ Birthdate: _____

List medical problems and surgeries:	**List medications you are taking:**

Do you or your family have a history of:

	SELF	FAMILY		SELF	FAMILY
Heart disease			Lung disease		
Diabetes			Cancer		
Stroke			Gastrointestinal disease		
High blood pressure			Neurological disease		
Liver disease			Arthritis		
Kidney disease			Vein or artery disease		
Other (describe)			Other (describe)		

Do you have any allergies to medications? ❑ Yes ❑ No Please list: _____

Allergy to Penicillin? ❑ Yes ❑ No _____

Allergy to Latex? ❑ Yes ❑ No _____

Allergy to Seafood? ❑ Yes ❑ No _____

Allergy to Dye:? ❑ Yes ❑ No _____

Do you drink alcohol? ❑ Yes ❑ No How many drinks per week? _____

Do you smoke? ❑ Yes ❑ No How long? _____ How much per day? _____

Do you use street drugs? ❑ Yes ❑ No Do you have AIDS or AIDS-related illness? ❑ Yes ❑ No

Do you have a living will in place? ❑ Yes ❑ No

Date of last tetanus immunization: _____ Date of last pneumococcal immunization: _____

WOMEN PATIENTS: Name of OB/GYN: _____

Date of last PAP test: _____ Last date of mammogram: _____