PATIENT INFORMATION
PLEASE PRINT

PATIENT INFORMATION:

NAME: _____ SEX ____M____F DATE OF BIRTH ____/____/____
ADDRESS: _____CITY: _____ STATE:____ ZIP CODE: _____
SS# ____/___/___ DRIVER'S LICENSE#_____MARITAL STATUS __SINGLE__MAR__DIV__WIDOW
HOME PHONE #(___)_____ WORK#:(___)_____ CELL#(___)_____
REFERED BY:_____E-MAIL ADDRESS: _____
EMPLOYER: _____ ADDRESS: _____CITY:_____STATE:__ZIP:_____
STUDENT:_____Y_____N IS YOUR CONDITION WORK RELATED? _____Y____N AUTO ACCIDENT ____Y_____N

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY:_____COPAY$____DEDUCTIBLE$_____IS IT MET? Y N
HMO?____ TRI-COUNTY:___ADVOCATE:___ PPO?_____ POS?____ EFFECTIVE DATE: ____/____/____
ADDRESS OF INSURANCE CO: _____CITY:_____STATE:____ZIP CODE:_____
ID#_____ GROUP#_____ PHONE #(____)_____
SUBSCRIBER'S NAME:_____ SUBSCRIBER"S DATE OF BIRTH ____/_____/_____
SUBSCRIBER'S EMPLOYER:_____ RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY:_____COPAY$_____ DEDUCTIBLE$_____IS IT MET? Y N
HMO?____ TRI-COUNTY:____ADVOCATE:_____ PPO? ____ POS?____ EFFECTIVE DATE: ____/____/____
ADDRESS OF INSURANCE CO:_____CITY:_____STATE:____ ZIP CODE: _____
ID#_____ GROUP#_____PHONE#(____) _____
SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DATE OF BIRTH ____/_____/_____
SUBSCRIBER'S EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY:

NAME:_____ RELATIONSHIP TO PATIENT:_____
ADDRESS:(if different than above):_____CITY:_____STATE:____ZIP CODE:_____
EMPLOYER:_____ADDRESS:_____CITY:_____STATE:___ZIP CODE_____
SOCIAL SECURITY #_____PHONE#_____ DATE OF BIRTH ____/____/____

IN CASE OF EMERGENCY:

NOTIFY:_____RELATIONSHIP TO PATIENT:_____PHONE # (____)_____
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment to Dr. Padmini Thakkar and to release Any medical information required. I certify the above information is correct to the best of my knowledge and understand that I am financially responsible for all charges subject to insurance coverage. I also understand that I am responsible for any deductibles and any services not covered by my insurance company. I further understand that I am liable for any legal and collection fees due to non-payment of services, including a $50 charge for any un-cancelled (no show appointments. In addition, I understand that withholding information or giving false information is considered a fraud. I, the undersigned, certify that I have read the foregoing and am the patient, or duly authorized by the patient, as the patient's general agent, to execute the above and accept it's terms.

SIGNATURE:_____PRINT NAME:_____DATE:____/_____/_____
PARENT/GUARDIAN SIGNATURE(if under 18) **_____DATE:_____/____/_____**
PRINT NAME:_____

PADMINI THAKKAR, M.D.
Patient Information

Date _____

Patient's Name _____ Home Phone _____
Cell Phone # _____ Spouses Phone # _____
Address _____ City _____ State _____ Zip _____
SS # _____ DOB _____ Sex MF Marital Status M S D W
Employer _____ Work Phone _____
Ref Dr. _____ Phone _____ Fax _____
Address _____ City _____State _____Zip _____
PCP _____ Phone _____ Fax _____

AUTO_____WORKMAN COMP:_____OTHER____DOI_____
APPROVED DX _____

Auto Policy Holder _____ Relationship _____
DOB _____ SS # _____
Address _____ City _____ State _____ Zip _____
PATIENT AUTO INS: _____ Phone _____
Address _____ City _____ State _____ Zip _____
Group # _____ ID #_____ Fax _____

OTHER PERSONS AUTO INS:
Name of Insured _____ Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____
Contact Person _____ Fax _____

WORKMAN COMP:
Employer _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____
Contact Person _____
Supervisors Name Reported To: _____
Phone _____ Ext: _____

SIGNATURE _____ DATE ____/____/____

PADMINI THAKKAR, MD; SC
300 Fox Glen
Barrington, IL 60010
(847) 382-6070

A detailed medical history is an important part of any physical examination. Careful attention to This questionnaire will assist us in performing a thorough evaluation. Please answer all of the questions above completely and to the best of your ability. If you need assistance please ask the receptionist at the front desk.

NAME HEALTH HISTORY: _____

Check	Sign/Symptoms	Explanation (or history)	Check	Sign/Symptoms	Explanation (or history)
____	Appendix	_____	____	Arthritis/Rheumatism	_____
____	Asthma	_____	____	Back Pain/ trouble	_____
____	Bolls	_____	____	Bone, Joint deformity	_____
____	Cancer present	_____	____	Cancer history	_____
____	Chronic Cough	_____	____	Colds (frequent)	_____
____	Depression	_____	____	Excessive worry	_____
____	Diabetes	_____	____	Dizziness/fainting	_____
____	Drug Addiction	_____	____	Ear, Nose, Throat	_____
____	Epilepsy/ fits	_____	____	Eye trouble	_____
____	Gallbladder	_____	____	Gallstones	_____
____	Goiter	_____	____	Hay fever	_____
____	Headaches	_____	____	Heart disease	_____
____	High BP	_____	____	Low BP	_____
____	Indigestion	_____	____	Jaundice	_____
____	Kidney Stones	_____	____	Blood in urine	_____
____	Amnesia	_____	____	Loss of memory	_____
____	Nerve prob.	_____	____	Neuritis	_____
____	Painful Chest	_____	____	Chest pressure	_____
____	Painful urination	_____	____	Heart palpitation	_____
____	Paralysis	_____	____	Hemorrhoids	_____
____	Colon/ rectal	_____	____	Reaction to medications	_____
____	Rheumatic fever	_____	____	Ruptures	_____
____	Scarlet fever	_____	____	Erysipelas	_____
____	Severe tooth/gum	_____	____	Shortness of breath	_____
____	Sinusitis	_____	____	Skin rash	_____
____	Stomach, liver, intestinal	_____	____	Sugar/albumin in urine	_____
____	Night sweats	_____	____	Swollen/painful joints	_____
____	Trick/locked joints	_____	____	Insomnia	_____
____	Tuberculosis	_____	____	Tumor, growth, cyst	_____
____	Venereal disease	_____	____	Other sexual trans. disease	_____

SIGNATURE: _____ DATE: _____
Print Name: _____

PADMINI THAKKAR, MD: ABFP
300 FOX GLEN
BARRINGTON, IL 60010
847-382-6070

Do you or have you worn glasses or contacts? _____
Do you or have you worn hearing aids? _____
Do you or have you worn a brace/back support? _____
Do you or have you lived with someone who has had tuberculosis? _____
Do you or have you coughed up blood? _____
Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? ____ How much? _____ For how long?
Do you drink caffeine? ____ How much? _____ For how long? _____
Do you use recreational drugs? ____ How much? _____ For how long? _____
Do you use herbal supplements? ____Wat kind? _____ For how long? _____
Do you use vitamins? _____ What kind? _____ For how long? _____
Do you have any sexually transmitted diseases? _____ Which ones? _____
Have you recently experience weight loss? ___ lbs. _____gain? _____ lbs? _____
Do you have any drug allergies? (Please list)_____
Past hospitalizations (list) _____
Past surgeries (list) _____
What medications are you presently on? _____
List any family medical histories _____
Other remarks _____

FEMALES ONLY

Have you ever been pregnant? ____ If yes, how many children? _____ Ages? _____
Have you had any pregnancy problems or miscarriages? _____
Do you have painful periods? _____
Age periods started ___ Date of last period _____
Interval between periods _____ Duration of last period _____
Date of last pap smear _____
Past history of periods: normal ____ excessive _____ Scant _____
Present method of birth control _____

SIGNATURE _____. Date _____
Print name: _____

Dr. Padmini Thakkar
Family Medicine
300 Fox Glen
Barrington, Il. 60010
847-382-6070

PRIVACY NOTICE

(As required by Federal Regulations)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Treatment

I hereby give my consent and authorize the above named practice to examine me and render any necessary medical testing or treatment for my health and well-being.

Payment

I understand that this practice will file claims with my medical insurance carrier(s). I hereby give my consent and authorize this practice to release any information acquired in the course of my examination and treatment to my insurance company(ies) pertinent to billing. I recognize that the information may include facts about drug/alcohol use, mental health, sexually transmitted diseases, and/or HIV/AIDs testing. I authorize the release of any information pertinent to my case to my insurance company(ies) adjuster or attorney involved in my case.

I hereby authorize my insurance company(ies) to pay this practice for any professional/medical expense benefits allowable and payable under my current insurance policy(ies) as payment toward the charges for services rendered. I agree to pay, in a timely manner, any balance not covered by my insurance.

Health Care Operations

I also understand there are other instances when disclosure will be necessary on my behalf when ordering diagnostic/screening test, prescription drugs, hospitalization, or physical studies; or when referring me to another physician for consultation or surgery, or when my insurance company conducts a particular health study. I hereby give my consent and authorize the release of the necessary information in such cases.

Additionally, I understand that I may revoke this authorization in part or in whole at anytime by written instruction to this practice.

Legal Requirements

This practice is required by law to maintain and protect the privacy of your individual health information. We are committed to your health and well-being as well as your

Individual privacy and rights as stated in this Patient Rights and Privacy Notice.

Dr. Thakkar reserves the right to amend this Privacy Notice as the need arises. Any Amendments to the Privacy Notice will be posted in the office reception areas.

Patient Rights

As a patient of this, you have the right to:

- Request restrictions on certain uses and disclosures
- Receive confidential communications from this practice
- Inspect your protected health information and to receive a copy of the same for a copying fee ranging from $25 to $50 depending upon the size of your patient chart.
- Amend any incomplete or incorrect protected health information by discussing the problem with your physician.
- Register a complaint with this practice by calling your personal physician or by contacting the department of Health and Human Services.

If you want to correct, amend or place restrictions on your chart information, or ask questions about this Notice, call Dr. Thakkar at (847) 382-6070

I have read and understand this Notice.

_____ _____

Signature of Patient or Legal Guardian Date

Listed below is the name of the person or people I authorize you to release any information to. This authorization remains in effect until you receive written notice to terminate the authorization on my behalf.

_____ _____

Name Date

_____ _____

Name Date

_____ _____

Name Date