



PATIENT INFORMATION FORM

Last Name: _____ **First Name:** _____ **M.I.:** _____
Street: _____ **City:** _____ **State:** _____ **Zip:** _____
Date of Birth: ____/____/____ **Social Security#:** ____-____-____ **Gender (circle one):** Male Female
Email Address: _____

In an effort to provide you with timely information regarding your health care, we are asking that you provide us with the following:

Please circle one

Daytime Phone Number: ____-____-____ Home Work Cell
Evening Phone Number: ____-____-____ Home Work Cell
Other Phone Number: ____-____-____ Home Work Cell

If you are not available at the time we try to call you, may we:

Disclose Medical information on an answering machine: Yes No N/A
 Leave appointment information on an answering machine: Yes No N/A

Emergency Contact Person: _____ **Relationship:** _____
Emergency Contact Phone (Home): ____-____-____ (Work): ____-____-____

Is this visit for the purpose of (circle one): workers' comp auto-accident personal self pay

It is the responsibility of the patient to contact us with any changes to the above information in writing.

Primary Medical Doctor: _____ **City:** _____
Referring Physician: _____ **Phone:** ____-____-____

PATIENT PRIVACY ACT / INFORMATION AUTHORIZATION

The following person(s) can inquire, pick up records, prescriptions, x-rays, etc., and take messages regarding my health information: (Please include any physicians, friends, or relatives to whom you may allow to take part in caring for your health)

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Signature: _____ **Date:** ____/____/____

Name of Authorized Guardian if patient is a minor: _____

PATIENT HEALTH HISTORY



G&TSPORTSMEDICINE
ORTHOPAEDICS

Patient Name: _____ Date of Birth: ____/____/____

List medications you are currently taking: _____

Allergies: None (circle if none) _____ Previous Surgery(ies): Y N _____

FAMILY HISTORY:

Heart Disease____ Diabetes____ Hypertension____ Bleeding Problems____ Other_____

Do you smoke? Y N If you do, how much a day?_____ How many years?_____

Do you drink alcohol? Y N If you do, how much a day?_____ For how many years?_____

Do you/have you previously used drugs? Y N Do you live alone? Y N

Any information you provide will not be released and will only be used for the purpose of our office.

Please circle conditions you currently have or have had:

Anemia	Cancer	Gout	Migraine Headaches	Rheumatic
Anorexia	Cataracts	Heart disease	Mononucleosis	Scarlet Fever
Appendix	Chickenpox	Hepatitis	Multiple Sclerosis	Stroke
Arthritis	Diabetes	Hernia	Mumps	Thyroid Problem
Asthma	Emphysema	High Cholesterol	Pacemaker	Tuberculosis
Bleeding Disorders	Epilepsy	High Blood Pressure	Pneumonia	Typhoid Fever
Breast Lump	Glaucoma	Kidney Disease	Polio	Ulcers
Bronchitis		Liver Disease	Prostate Problem	Venereal Disease
Bulimia		Measles		

Please circle conditions you currently have or have had:

AIDS/HIV Positive Alcoholism Chemical Dependency Psychiatric Care

Please circle symptoms you currently have or have had in the past 3 months:

<u>GENERAL</u>	<u>GASTROINTESTINAL</u>	<u>EYE,EAR,NOSE,THROAT</u>	<u>WOMEN ONLY</u>
Chills	Appetite poor	Bleeding gums	Abnormal pap smear
Depression	Bloating	Hoarseness	Bleeding between periods
Dizziness	Bowel changes	Nosebleeds	Breast Lump
Fainting	Constipation	Persistent cough	Hot Flashes
Fever	Diarrhea	ringing in ears	Are you pregnant?__
Headache	Nausea		No. of children ____
Loss of sleep	Rectal bleeding	<u>CARDIOVASCULAR</u>	
Loss of weight	Stomach Pain	High Blood Pressure	
Gain of weight	Vomiting	Irregular Heartbeat	<u>GENITO-URINARY</u>
Nervousness	Vomiting Blood	Low Blood Pressure	Blood in urine
Sweats		Poor Circulation	Frequent Urination
		Rapid Heartbeat	Lack of Bladder control
<u>MUSCLE/JOINT/</u>	<u>SKIN</u>	Swelling of Ankles	Painful Urination
<u>BONE</u> (Pain,	Bruise easily	Varicose Veins	
Weakness,	Hives	Chest Pain	
Numbness in)	Itching		
Arms – Hips	Change in moles		
Back – Legs	Rash		
Feet – Neck	Scars		
Hands – Shoulders	Sore that won't heal		

**ASSIGNMENT OF BENEFITS
& RELEASE OF INFORMATION**



Commercial Insurance

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to (name of patient) _____.
I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian: _____

Medicare/Medicaid Insurance

Beneficiary _____ Medicare Number _____ Medigap ID Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Kevin C. Tu, MD, and Christos S. Giannoulas, MD, for any service furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

Beneficiary Signature: _____ **Date of Birth:** ____/____/____

Insurance Information: Who is the insurance policy subscriber? _____

Name of Insurance Plan/Group: _____ **Subscriber's Social Security #:** ____ - ____ - ____

Subscriber's Employer: _____ **Effective Date of Insurance:** _____

Secondary Insurance Information: _____

Name of Insurance Plan/Group: _____

Please know your insurance. It is your responsibility. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance.

AUTHORIZATION OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, or any other health plan to: Kevin C. Tu, MD and Christos S. Giannoulas, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all necessary information to insurance carriers or any other services including billing and transcription, concerning my illness and treatments in order to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature: _____ **Date:** ____/____/____

Name of Authorized Guardian if patient is a minor: _____

FOR WORKERS' COMPENSATION CASES



PLEASE FILL OUT AS MUCH AS POSSIBLE

Today's Date: ____/____/____

Patient Name: _____

Social Security Number: ____ - ____ - ____ Date of Birth: ____/____/____

Appt. Date: ____/____/____ Date of Injury: ____/____/____

Employer Name: _____

Employer Address: _____

Contact Name: _____ Title: _____

Phone Number: ____ - ____ - ____ Fax Number: ____ - ____ - ____

Workers' Comp Carrier Name: _____

Address: _____

Claim Number: # _____

Contact Name (Adjuster): _____

Contact Phone: ____ - ____ - ____ Fax Number: ____ - ____ - ____

Please note that Workers' Compensation benefits can be denied and you will be held responsible for all charges for rendered professional services.

**G&T ORTHOPAEDICS
AND SPORTS MEDICINE**



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847.439.2314

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Elmhurst, IL 60126
630.782.1174

Notice of Privacy Practices Acknowledgement

This notice advises you about the ways in which we may use and disclose your protected health information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you, which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of G&T Orthopaedics and Sports Medicine, S.C. Notice of Privacy Practices at the time of registration, or previously viewed online.

Signature _____ Date _____

Notificación del Reconocimiento de la Política de Privacidad

Esta nota es para informarle a usted acerca de las formas en que nosotros podemos revelar su información protegida médica (PHI). Información protegida médica significa cualquier información médica que se pueda utilizar para identificarlo a usted y es posible que este relacionada con su salud o condición física o mental pasada, actual, o futura y relacionados con servicios médicos. También describe sus derechos y nuestras obligaciones con respecto a su información protegida médica. La ley requiere que nosotros le proveamos a usted esta nota de aviso en la cual se explican nuestras obligaciones legales y políticas de privacidad.

Con mi firma reconozco que me han ofrecido una copia del G&T Orthopaedic and Sports Medicine, S.C. Notice of Privacy al momento de registracion. Lo mismo pero en español.

Firma _____ Fecha _____