Villa Medical Arts

New Patient Forms

New Patients,

To expedite your check-in process, please print and complete the following pages.

If you have access to a fax machine, please fax them along with a copy of your driver's license and insurance card (front and back) to:

630-832-7907

If you do not have access to a fax machine but are able to complete the documents, simply bring them with you on your appointment along with proof of identification and insurance card.

NOTE: If your insurance carrier requires a referral prior to the visit, please bring it along as well.

Please feel free to contact us if you have any questions.

Thank you.

Villa Medical Arts

EMAIL PERMISSION FORM

May we use your email address to send you information?

This form requests that you allow us to send you general notices, including reminders of appointments, patient satisfaction surveys and clinic newsletters, via email. You will be able to remove your name from this list at any time and we will ***NOT*** provide your email address to anyone else.

Permission Agreement

I hereby authorize Villa Medical Arts to furnish to me general notices, including reminders of appointments, patient satisfaction surveys, and clinic newsletters, via email at the address indicated below.

I understand that it is my obligation to inform you of any changes in my email address after the date hereof. I further understand that my records and medical information are protected under federal and state confidentiality regulations and that no confidential information will be included in any general notices provided to my email address. I also understand that I may revoke this authorization at any time, in writing or by email to except to the extent that action has been taken prior to the revocation. Upon revocation of authorization further notifications by email will cease immediately.

This authorization will expire upon my request to transfer my records to another physician outside this practice or my notification to you that I will no longer be a patient of your practice, whichever is the case.

First Name____

Last Name____

Birthdate____

Email Address____

I grant *VMA* permission to send notices via email according to the statement above.

___________________________________ ______________________________

Signature Date

Villa Medical Arts

Financial Policy

Thank you for selecting Villa Medical Arts for your health care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information is provided:

HMO/PPO/Other Insurance Coverage:

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and driver's license. **All copayments are due prior to seeing the physician. You will be responsible for any coinsurance and deductibles and will be billed for them.** If your insurance carrier requires a referral from your primary care physician, this must be presented at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Medicare:

Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charge after you pay your normal annual deductible. You are responsible for any amount applied to your deductible and the 20% coinsurance. If you have a secondary insurance, as a courtesy we will submit to the particular carrier any remaining balance. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory:

Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients:

For patient's with no insurance, the guarantor is responsible for the bill at the time of service.

Payments:

Payments can be made by cash, check, Visa, Mastercard or Discover

Returned Check:

A charge of $25.00 will be added for all returned checks.

Collection Accounts:

If an account has gone to collections, the patient may make an appointment, however, payment in full at the time of service is required.

Certified Letter Sent:

If the patient has received a certified letter from us, they are not seen, no appointment should be made.

Medical History

*Date:*________________________

Villa Medical Arts
10 E. Central Blvd.
Villa Park, Il 60181

Name ________________________________Age___Birth date________________Sex M F

Address______________________________________Home phone___________________________
______________________________________Work phone___________________________
______________________________________Emergency contact______________________

Occupation_____________________________ Phone____________________________________
Employer____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Married, spouse's name____
Children's names and ages____

Allergies to Medications, Xray dyes, Latex, or other ☐ **No** ☐ **Yes**
if yes, please list name(s) of medicines(s) and types(s) of reaction:
____
____
____
____

Past Medical History and Review of Systems
Please circle if **you** have had problems with or are currently complaining about any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. TB
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Constipation
22. Diarrhea
23. Blood in stool
24. Ulcers
25. Change in bowel habits
26. Unexplained weight gain/loss
27. Hemorrhoids
28. Gall bladder disease
29. Colitis
30. Hepatitis or jaundice
31. Thyroid disease
32. Radiation to head or neck
33. Headache
34. Kidney diseases
35. Kidney stones
36. Arthritis
37. Low back problems
38. Skin diseases
39. Blood disorders
40. Venereal disease
41. Anxiety
42. Depression
43. Anemia
44. Hernia
45. AIDS/AIDS related illness

Do you smoke? Yes No Packs/day________
Alcohol? Yes No Drinks/week ________
Do you use illicit drugs Yes No **In the past**? Yes No
Do you have an Advanced Directive or Living Will? Yes No
When was your last tetanus shot?__________
When was your last complete physical? ________________

Family History (Please circle)

1. Coronary artery disease
2. Kidney disease
3. Gastrointestinal disease
4. Diabetes
5. Liver disease
6. Neurological Disease
7. Stroke
8. Lung Disease
9. Vein or artery disease
10. Cancer

Gynecologic and Obstetric History – WOMEN

Date of last PAP test: _______________

Age at onset of periods:__________ Frequency: ___________ Length of period: _____________
Pregnancies:___________ Births:_______________ Miscarriages: _______________

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe)________________________
Leakage of urine: ☐ No ☐ Yes (Please describe)________________________
Pelvic pain: ☐ No ☐ Yes (Please describe)________________________
Abnormal discharge: ☐ No ☐ Yes (Please describe)________________________
History of abnormal Pap Smear: ☐ No ☐ Yes (Please describe)________________________

Villa Medical Arts 10 E. Central Blvd. Villa Park, IL 60181

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name_______________ Age_____ Birthday __________ Sex_______

Address_______________ APT. # _______________

CITY/STATE _______________ ZIP _______________

SOCIAL SECURITY # ________-________-________HOME PHONE _______________CELL_______________

MARITAL STATUS ________SPOUSE'S NAME _______________ STUDENT-- FULL TIME_____ PART TIME ______

EMPLOYER NAME_______________WORK PHONE_______________

INJURY-WORK RELATED. _________ AUTO ACCIDENT? _________ OTHER (SPECIFY) _______________

RESPONSIBLE PARTY (*IF OTHER THAN THE PATIENT)*

NAME _______________ RELATIONSHIP ___________ HOME PHONE _______________

ADDRESS _______________ CITY/STATE _______________ ZIP _______________

SOCIAL SECURITY # ________-________-________ DOB ________/________/________

PATIENT INSURANCE INFORMATION *(Must present insurance card at time of service.)*

POLICYHOLDER NAME _______________ RELATIONSHIP _____________ BIRTH DATE____________

ADDRESS_______________CITY/STATE_______________ZIP_______________

INSURANCE NAME_______________POLICYHOLDER SS # ________-________-________

POLICY # _______________ GROUP # _______________COVERAGE TYPE SINGLE _______ FAMILY________

POLICYHOLDER'S EMPLOYER _______________ EMPLOYER PHONE # _______________

SECONDARY INSURANCE NAME *(Medicare & HMO Patients Only-- must present card at time of service)*

POLICYHOLDER NAME _______________RELATIONSHIP______________BIRTHDATE ____________

ADDRESS _______________ ____________CITY/STATE_______________ ZIP_______________

INSURANCE NAME_______________ POLICYHOLDER SS # ________-________-________

POLICY # _______________ GROUP # _______________HOME PHONE_______________

EMERGENCY CONTACT

NAME_______________RELATIONSHIP_______________PHONE_______________

HOW WERE YOU REFERRED TO US? _______________

I GIVE PERMISSION FOR TREATMENT TO MYSELF OR DEPENDENTS. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I FURTHER AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PROVIDER ANY BENEFITS DUE ME UNDER MY INSURANCE PLAN

PATIENT/GUARDIAN SIGNATURE_______________DATE_______________

VILLA MEDICAL ARTS
10 E. Central Blvd.
Villa Park, IL 60181
(630)832-9000

Patient Name:____

Consent to the Use and Disclosure of Medical Information for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my medical information by ***VILLA MEDICAL ARTS*** *for* the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduct healthcare operations of the practice. I understand that treatment by the practice may be denied if I do not sign this consent.

I understand that I have the right to request restrictions as to how this information is used or disclosed for treatment, payment or healthcare operations and that ***VILLA MEDICAL ARTS*** is not required to agree to the restrictions that I may request, but if the practice agrees to a restriction, the practice is bound by the agreement.

I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on prior consent.

I understand and have been provided with ***VILLA MEDICAL ARTS*** *Notice of Privacy Practices* that provides information about how the practice may use and disclose medical information. I understand that I have the right to review the notice prior to signing this consent.

VILLA MEDICAL ARTS has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by *calling the office and requesting a revised copy be sent in the mail or asking for one when I am in the office.*

Signature:________________________________Date:__________________

Relationship to Patient:____