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
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**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Birth date</th>
<th>Sex</th>
<th>M</th>
<th>F</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Home phone</th>
<th>Work phone</th>
<th>Emergency contact</th>
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</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Occupation</th>
<th>Phone</th>
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<table>
<thead>
<tr>
<th>Employer</th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Separated</th>
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If Married, spouse’s name

<table>
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<tr>
<th>Children’s names and ages</th>
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**Allergies to Medications, Xray dyes, Latex, or other**

- **No**
- **Yes**

If yes, please list name(s) of medicines(s) and types(s) of reaction:

<p>| |</p>
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**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  
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**

**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:**
- Yes (Please describe)
- No

**Leakage of urine:**
- Yes (Please describe)
- No

**Pelvic pain:**
- Yes (Please describe)
- No

**Abnormal discharge:**
- Yes (Please describe)
- No

**History of abnormal Pap Smear:**
- Yes (Please describe)
- No
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 ______________ BIRTH DATE____________
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_______________
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: ____________________________