Your Medicos S.C.
1300 Busch Parkway
Buffalo Grove, IL 60089
(847) 850-5882

PATIENT INFORMATION FORM

Name _____

Home Phone (_____) _____ **Cell Phone (_____)**_____

DOB_____ **Email:(Please Print)** _____

Home Adress_____

City_____ **State**_____ **Zip**_____

In case of emergency: Contact name: _____**Ph #** _____

Whom may we thank for referring you to us _____

Insurance Name _____ **Policyholder's Name**_____

Insurance ID #_____**SS#**_____

Please read and initial each of the following:

_____ **Assignment of Insurance Benefits:** I hereby authorize direct payment of medical benefits for services rendered in the office**. I understand that I am financially responsible for any balance not covered by my insurance.** I further understand that if I default, and outside collection effort are requested. I will be responsible for all collection fees, court costs, attorney fees, as well as any interest allowed by law.

_____ **Authorization to Release Information**: I at this moment authorize **Your Medicos S.C**. to release any medical information about my treatment, and permit any insurer to inspect my medical record regarding any charges arising from this treatment.

_____ **Cancellation Policy**: **A $25 fee** will be charged for missed appointments: Unless the appointment is canceled at least one business day before the scheduled time.

_____ **Record Request:** We keep medical records in our archive for three years. If you requested a copy of your medical records, a charge of S20-S35 would be assessed to cover the cost of copies.

I understand and agree that (regardless of my insurance status), I am responsible for any balance on my account for any professional services rendered. I have carefully read all of the information above and answered all of the questions; I certify that the information provided here is true and correct to the best of my knowledge. I will notify you of any changes in my status or above information.

Patient Signature_____Date_____

DO YOU HAVE OR HAVE YOU EVER HAD

Heart Trouble Rheumatic Fever	YES ☐	NO ☐
High Blood Pressure	YES ☐	NO ☐
Dizziness/Fainting Tendency	YES ☐	NO ☐
Pacemaker	YES ☐	NO ☐
Epilepsy/Stroke	YES ☐	NO ☐
Bleeding Problems	YES ☐	NO ☐
Anemia or Blood Disorders	YES ☐	NO ☐
Abnormal Response to Colds	YES ☐	NO ☐
Poor Wound Healing	YES ☐	NO ☐
Skin Pigment Problem	YES ☐	NO ☐
Keloids or Abnormal Scarring	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐
Kidney or Bladder Trouble	YES ☐	NO ☐
Hepatitis/Liver Disease	YES ☐	NO ☐
Fever Blister/Cold Sore	YES ☐	NO ☐
Tuberculosis	YES ☐	NO ☐
Stomach Ulcers	YES ☐	NO ☐
Asthma	YES ☐	NO ☐
Cancer	YES ☐	NO ☐
Radiation Treatment	YES ☐	NO ☐
Do You Smoke	YES ☐	NO ☐
Currently Under Medical Care	YES ☐	NO ☐
Frequent/Severe Headaches	YES ☐	NO ☐
Joint or Muscle pain	YES ☐	NO ☐
Do You Have Scars or Stretch Marks?	YES ☐	NO ☐
Any Past Surgeries	YES ☐	NO ☐

If So, What Past Surgeries

ARE YOU SENSITIVE TO:

Any Local Anesthetic	YES ☐	NO ☐
General Anesthetic	YES ☐	NO ☐
Iodine	YES ☐	NO ☐
Medicine	YES ☐	NO ☐
Food	YES ☐	NO ☐

ARE YOU TAKING OR HAVE YOU TAKEN?

Cortisone	YES ☐	NO ☐
Steroids	YES ☐	NO ☐
Anticoagulants	YES ☐	NO ☐
Blood Thinners	YES ☐	NO ☐
Tranquilizers	YES ☐	NO ☐
Sedatives	YES ☐	NO ☐
Insulin	YES ☐	NO ☐

LIST ALL MEDICATION YOU ARE CURRENTLY ON:

Aspirin	YES ☐	NO ☐

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