



# Crescent Primary Care Physicians

where caring for your family comes first

2132 Deep Water Lane  
Naperville, IL 60564 Suite 228  
Phone: (630) 922-1400 Fax: (630) 904-7378

Patient's Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_  
SSN: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Office phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Name of Spouse / Parent / Legal Guardian: \_\_\_\_\_  
Employer / Address of Spouse / Parent / Legal Guardian: \_\_\_\_\_  
Emergency contact name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **PATIENT EMPLOYER INFORMATION**

Employer name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Patient's occupation: \_\_\_\_\_  Retired?

### **INSURED PERSON (IF NOT PATIENT)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

### **INSURANCE**

Medicaid # (if applicable): \_\_\_\_\_ Medicare # (if applicable): \_\_\_\_\_  
Policy holder Date of Birth: \_\_\_\_\_ Primary Insurance Company Name: \_\_\_\_\_  
Plan name: \_\_\_\_\_ Plan #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Group # (if applicable): \_\_\_\_\_ ID # (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary Insurance Company Name: \_\_\_\_\_  
Group # (if applicable): \_\_\_\_\_ ID # (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

### **MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. \_\_\_\_\_ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's \_\_\_\_\_ SSN: \_\_\_\_\_

**GENERAL MEDICAL INFORMATION**

Describe the current medical problem/reason for today's visit: \_\_\_\_\_

Present medications: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Allergies (e.g., Itchiness or hives) to specific brands of soap/laundry detergent: \_\_\_\_\_

Other physicians currently treating you: \_\_\_\_\_

Previous or other medical problems: \_\_\_\_\_

List any previous surgeries or hospitalizations (include number of miscarriages and live births): \_\_\_\_\_

Females only: Are you pregnant planning a pregnancy or nursing a child?  Yes  No

Do you smoke?  No  Yes  Cigarettes  Pipe  Cigars No. of years: \_\_\_\_\_ How much? \_\_\_\_\_

Interested in stopping?  Yes  No

Do you regularly drink alcohol?  Yes  No How many ounces/beers per day? \_\_\_\_\_

Do you regularly drink coffee?  Yes  No How many cups per day? \_\_\_\_\_

Are you under a lot of pressure at work?  Yes  No Please describe: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

Have you ever had any of the following (check all that apply):

- Chest pain/pressure/tightening \_\_\_\_\_
- Asthma \_\_\_\_\_
- Kidney disease \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Dizzy spells \_\_\_\_\_
- Shortness of breath \_\_\_\_\_
- Heart attack \_\_\_\_\_
- Cancer \_\_\_\_\_
- TB/Lung disorder \_\_\_\_\_
- Stroke \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Ulcers \_\_\_\_\_
- Headaches \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Skin disorders \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Difficulty hearing \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Allergies or Eczema \_\_\_\_\_
- Anemia \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Depression \_\_\_\_\_
- Memory loss \_\_\_\_\_
- Digestive problems \_\_\_\_\_
- Blood in stool \_\_\_\_\_
- Hemorrhoids \_\_\_\_\_
- Frequent urinary infections \_\_\_\_\_

**HEPATTIS C RISK FACTOR**

- Blood transfusion prior to 1992
- Contact with blood/bodily fluid
- Shared razor/toothbrush
- IV drug use (1 + times)
- Tattoos
- Body piercing

**IMMUNIZATIONS**

(Year last received, if known)

**FAMILY HISTORY**

		Father	Mother	Father's Parents	Mother's Parents	Siblings
Small pox _____	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus _____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid _____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio _____	Eczema / Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza _____	Heart attack / Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia _____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella _____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis _____	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MISCELLANEOUS NOTES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_