## Surgical Associates of Oak Park & River Forest

## Dr. Gerald E. Lynch

Please complete, sign, and return with copy of insurance card(s)

| Patient Name | Date Of Birth / / | Age | Sex M F | Marital Status S M D SEP W |
|---|---|---|---|---|
| Home Address | City | State | Zip Code | Phone# |
| Social Security | E-Mail Address | | | Cell# |
| Emergency Contact | Phone # | | Relationship | |
| Advance Directive Contact | | | | Phone# |
| Referring Physician: | | | | Phone# |
| Patient Employer | | | | Phone # |

### Consent and Release Medical Information

Please be sure to list all telephone numbers where you may be reached and person(s) other than yourself we may speak to regarding your personal information, diagnosis and results.

| Name | Relationship | Phone# |
|---|---|---|
| | | |
| | | |

This authorization will not expire and will remain in effect until written notice is received in our office. Please initial_____

### Patient Authorizations

**Assignment of Insurance Benefits and Payment For Services**

I here by authorize payment of all medical insurance benefits, including any major medical benefits, directly to SAOPRF. which are payable to me under the insurance policy for services rendered by SAOPRF.
I further authorize the release of any information for processing my insurance claim. A copy of authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance policy. If my account if referred to collection, I will be responsible for reasonable attorney's fees and collection costs.

**Authorization to Release Medical Records**

I here by authorize SAOPRF to release medical information to other providers participating in my care and as it relates to as needed basis for other physicians consultants. In addition, I authorize other providers participating in my care to provide copies of medical records to SAOPRF on an as needed basis. This authorization and payment agreement is made in Cook County Illinois.

**Notice of Privacy Practices**

I here by authorize SAOPRF. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. You may request a copy of this Notice by asking any of the SAOPRF. Staff.

**Picture Consent**

I here by authorize SAOPRF to take clinical photographs of me or parts of my body as part of this medical practice. Any photographs taken of me will be kept in my chart as a part of my medical record. The clinical photographs shall be used for medical record purposes and shall remain the property of SAOPRF

Patient Signature or Responsible Party

Date

# Surgical Associates of Oak Park and River Forest
# Dr. Gerald E. Lynch

## Medication List

*Dear Patient: List all medication you're currently taking including over-the-counter and herbal medications and any new medications .*

**Allergies:** _____

| *MEDICATION HISTORY RECORDED & VERIFIED BY:* | *Date Recorded:* _____ |
|---|---|

| ***Medication Name*** | ***Dose (mg, mcg)*** | ***Frequency (How often)*** | ***Discharge*** |
|---|---|---|---|
| 1. | | | D |
| 2. | | | D |
| 3. | | | D |
| 4. | | | D |
| 5. | | | D |
| 6. | | | D |
| 7. | | | D |
| 8. | | | D |
| 9. | | | D |
| 10. | | | D |
| 11. | | | D |
| 12. | | | D |
| 13. | | | D |

CHECK HERE IF THIS IS AN ADDENDUM TO/ OR REVISION OF PREVIOSLY COMPLETED MEDICATION LIST

Nurse Signature:_____ Date/Time _____

Nurse Signature:_____ Date /Time_____

Nurse Signature:_____ Date/ Time_____

Surgical Associates of Oak Park & River Forest

Dr. Gerald E. Lynch
*General Surgery*

## Family Medical History

| | Age | Disease | Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sibling's | | | |
| | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |
| | | | |
| | | | |

Review of systems: Please Circle Appropriate symptoms below:

- ☐ Weight/Fever
- ☐ Skin
- ☐ Ears/Nose
- ☐ Eyes
- ☐ Cardiovascular
- ☐ Urinary
- ☐ Muscles
- ☐ Neurological
- ☐ Psychiatric
- ☐ Endocrine
- ☐ Blood
- ☐ Recent weight change
- ☐ Skin Cancer
- ☐ Hearing change
- ☐ Vision changes
- ☐ Heart Trouble
- ☐ Coughing
- ☐ Constipation/Diarrhea
- ☐ Painful Urination
- ☐ Back pain/Joint pain
- ☐ Numbness/Tingling
- ☐ Depression
- ☐ Hormone problem
- ☐ Bruise easily
- ☐ Fatigue
- ☐ Wound
- ☐ Fever
- ☐ Rash
- ☐ Nosebleeds
- ☐ Headaches
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Nausea
- ☐ Blood in urine
- ☐ Gout
- ☐ Stroke
- ☐ Anxiety
- ☐ Diabetes
- ☐ Bleeding
- ☐ Mouth Problem
- ☐ Fainting
- ☐ Chills
- ☐ Hives
- ☐ Sinus Problem
- ☐ Dizziness
- ☐ Swelling
- ☐ Short of breath
- ☐ Abdominal Pain
- ☐ Kidney Stones
- ☐ Stiffness
- ☐ Seizures
- ☐ Nervousness
- ☐ Steroid Use
- ☐ Anemia
- ☐ Insomnia
- ☐ Bloody Stool
- ☐ Swollen Glands

Anything else we should know:

_____

_____

_____

Breast Patients:

Any family history of breast cancer? ☐Yes ☐No

Any history of hormone use? ☐None ☐Birth Control Pills ☐Hormone Replacement

Patient Signature:_____ Reviewed by Doctor:_____

Surgical Associates of Oak Park & River Forest

Dr. Gerald E. Lynch
*General Surgery*

What is the reason for your visit? _____

History of present illness? _____

How long have you had this? _____

When did it start? _____

Severity? _____

PAST MEDICAL HISTORY

| Have you ever had the following circle: | *(select Yes or No)* | |
|---|---|---|
| Heart Disease | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| Aids-HIV | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No |
| Mitral Valve Prolapsed | ☐ Yes | ☐ No |
| Bleeding Tendency | ☐ Yes | ☐ No |
| Hepatitis | ☐ Yes | ☐ No |

Anything else we should know about your medical history? _____

| | TYPE/REASON | WHEN | HOSPITAL |
|---|---|---|---|
| Previous Hospitalizations | | | |
| Surgeries | | | |
| Serious Illness | | | |

MEDICATIONS

Do you take aspirin, Plavix, Coumadin, or other blood thinner? ☐ Yes ☐ No

Do you have any allergies? _____

Use of Alcohol: ☐ Never ☐ Previously Quit ☐ Daily Amount: ☐1-2 3-4 ☐more than 5

Use of Tobacco: ☐ Never ☐ Previously Quit ☐ Daily Amount: ☐1-2 3-4 ☐more than 5

☐ **Current Packs**_____ ☐Daily ☐Week ☐Month

☐ **Check box if advised patient to stop Tobacco use**

# ATTENTION ALL PATIENTS OF
# SURGICAL ASSOCIATES OF OAK PARK AND RIVER FOREST

## ALL F.M.L., ADISABILITY AND OR ANY OTHER MISCELLANEOUS FORMS

That require documentation and the Doctor's signature will bow be subject to the following charges:

| | | |
|---|---|---|
| 1. | Initial Form | $25.00 |
| 2. | Additional Forms | $15.00 |

These charges are not covered by insurance or Medicare and will be collected prior to completion of forms

Due to the increased cost of copying supplies, please take note of our new copy charges

Medical Record Copies
As per the Illinois State Comptroller's Office

| | |
|---|---|
| • Handling Charge | $25.00 |
| • Copy Pages 1-2 | $.93 |
| • Copy Pages 26-50 | $0.62 |
| • Copy pages in excess of 50 | $0.32 |

I have read and understood the above policy

_____ _____

Signature Date

Surgical Associates of Oak Park and River Forest

Dr. Gerald E. Lynch

1 Erie Court, Suite 7160

Oak Park, IL 60302

# PRIVACY PRACTICE ACKNOWLEDGEMENT

## Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**Patient Name:**_____ **Today Date:**_____

**Signature:**_____