VILLA MEDICAL ARTS
33 South Villa Ave., Suite 2
Villa Park, IL 60181
(630)832-9000

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name________________________ Age_____ Birthday________ Sex ____
Address ________________________________ APT. __________
City/State ________________________________ Zip __________
Social Security # ________-________-________ Home Ph#____________ Cell Ph#____________
Primary contact (X One) Home _________ Cell _________
Martial Status ____ Spouse's Name____________ Student: Full Time ___ Part Time ____
Race______________ Ethnicity ________________ Language______________
Employer Name________________________________ Work Ph#____________
Injury-Work Related_____ Auto Accident? _____Other (Specify) ________________
E-Mail Address________________________________
Pharmacy________________ Address ____________________ Ph#__________

RESPONSIBLE PARTY *(IF OTHER THAN THE PATIENT)*

Name________________________ Relationship____________ Ph#__________
Address ________________________ City/State ________________ Zip__________
Social Security # ________-________-________ DOB ______/______/______

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

Policyholder Name ____________________ Relationship __________DOB ____/____/_____
Address ____________________ City/State ________________ Zip __________
Insurance Name ____________________ Policyholder SS #________-________-________
Policy#____________________ Group #____________Coverage Type Single_____ Family_____
Policyholder's Employer ________________________ Employer Ph#____________

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

Policyholder Name ____________________ Relationship __________DOB ____/____/_____
Address ____________________ City/State ________________ Zip________
Insurance Name ____________________ Policyholder SS #________-________-________
Policy#________________ Group #__________ Ph# ____________________

EMERGENCY CONTACT

Name ________________________Relationship__________ Ph# ________________

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____________________

(TURN OVER)

VILLA MEDICAL ARTS
33 South Villa Ave, Suite 2
Villa Park, IL 60181
(630) 832-9000

Patient Name ______________________________

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I hereby give my consent to Villa Medical Arts to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my record.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available by calling the office and requesting a revised copy be sent in the mail or asking for one when I am in the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: ______________________ **Date:** ______________

If you are not the patient, please specify you relationship to the patient ______________

Medical History *Date:*______________

Villa Medical Arts
33 S. Villa Ave., Suite 2
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

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
Physicians and Surgeons

33 South Villa Avenue, Suite 2
Villa Park, Illinois 60181
www.villamedicalarts.com
Phone: (630) 832-9000
Fax: (630) 832-7907

Contact Information – Authorization to Discuss Health Information

Patient Name ______________________ **Date of Birth** ____________

Patient Address ____

I, ___________________________**, authorize the following contacts to discuss my medical information and test results with my physician or medical staff.**

Name of Contact person and telephone number:

1. ____
2. ____
3. ____
4. ____

Signature of Patient: ____

FAMILY PRACTICE
Anthony Lin, M.D.
Eyad Homedi, M.D., P.C.

INTERNAL MEDICINE

Inna Milgram, M.D., P.C.

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Patient
Name ____

Notification of Fee for Missed Appointments

I acknowledge and understand Villa Medical Arts will charge a fee for a missed appointment. A missed appointment is a no-show or when a patient fails to call to cancel an appointment.

Signed: _______________________________________ Date: ________________

If you are not the patient, please specify relationship to the patient: ______________________