Perry L. Kamel, M.D.
737 North Michigan Avenue, Suite 620
Chicago, Illinois 60611
Fax: 312.573-9636
312.573.9626

HEALTH HISTORY FORM

Name: ______________________________ Social Security No: ____________________
Date: ________________ Birthdate: _____________

Reason for Visit: ____

Symptoms: Please check the symptoms you currently have or had in the past year:

General: Fever _____ Chills ____ Weight Gain ____ Weight Loss ____ Fatigue ____
Loss of Appetite ____
Eyes: Glaucoma ____ Retinopathy ____
ENT: Sinus Drainage ____ Hoarseness ____ Sore Throat ____
Heart: High Blood Pressure ____ Heart Attack ____ Chest Pain ____ High Cholesterol ____
History of Heart Valve Infection ____ Artificial Valve ____
Pulmonary: Shortness of Breath ____ Cough ____ Asthma ____ Emphysema/Bronchitis ____
GI: Abdominal Pain ____ Nausea ____ Vomiting ____ Heart Burn ____
Difficulty Swallowing ____ Change in Bowel Habits ____ Constipation ____
Diarrhea ____ Rectal Pain ____ Rectal Bleeding ____
GU: Male Blood in Urine ____ Urinary Frequency ____ Nocturnal Urination ____
Female Blood in Urine ____ Burning ____ Incontinence ____ Mammogram ____
Pelvic Exam and PAP Smear ____ Hormone Replacement Therapy ____
Joints/Muscle: Back Pain ____ Joint Pain ____ Joint Swelling ____
Skin: Rashes ____ Cancer ____
Neurologic: Stroke ____ Seizures ____ Headache ____
Psychiatric: Depression ____ Anxiety ____
Endocrine: Diabetes ____ Thyroid ____
Hematologic: Anemia ____ Swollen Glands ____ Easy Bruising ____

Medical History: Please list significant current and past medical problems:

1) ______________________ 2) ______________________ 3) _____________________

4) _____________________ 5) _____________________ 6) _____________________

Surgical History: Please list prior surgeries and date of operation:

1) ______________________ 2) ______________________ 3) _____________________

Medications: Please list medications you are currently taking, dose and frequency:

1) ______________________ 2) ______________________ 3) _____________________

4) _____________________ 5) _____________________ 6) _____________________

HEALTH HISTORY FORM (Cont'd.)

Name: ______________________________ Social Security No: ____________________
Date: ________________ Birthdate: _____________

Allergies: Please list medications you are allergic to and type of reaction:

1) ____________________ 2) ____________________ 3) ___________________

Health Habits: Please check the substances you use and describe how much you use:

Tobacco _________ Alcohol ___________ Caffeine ___________ Drugs ___________

Social History: Married ____ Divorced ____ Single ____ Widow ____ Partner ____

Children: _________________________ Occupation: ________________________________

Family History: Please fill in your family's health information:

	Age	Health Conditions	Age at Death	Cause of Death
Father	______	_______________________	______	___________________
Mother	______	_______________________	______	___________________
Brothers	______	_______________________	______	___________________
	______	_______________________	______	___________________
Sisters	______	_______________________	______	___________________
	______	_______________________	______	___________________

Any significant gastrointestinal illnesses in family members? Please list:

1) ____________________________________

2) ____________________________________

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor, or any members of his staff, responsible for any errors or omissions that I may have in the completion of this form.

____ _______________________
Signature Date

____ _______________________
Reviewed By Date

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Our office policy requires payment for all medical services at the time of visit, unless other arrangements have been made with the business manager.

____________________________ Date

PATIENT INFORMATION (PLEASE PRINT)

NAME: ____________________ DATE OF BIRTH: ____________

ADDRESS: ____________________ HOME# (   ) ____________

CITY: ____________ STATE: ________ ZIP__________ WORK# (   ) ____________

SOCIAL SECURITY #______________________SEX:_________ CELL# (   ) ____________

REFERRED BY: ____________________ MARITAL STATUS: S M D W SEP PART

PATIENT'S EMPLOYMENT INFORMATION

EMPLOYER: ____________________ OCCUPATION: ____________

ADDRESS: ____________________CITY:____________ STATE: ________ ZIP: ____________

SPOUSE/PARTNER'S INFORMATION

SPOUSE/PARTNER'S NAME: ____________________ SS# ____________

EMPLOYER: ____________________ WORK# (   ) ____________

ADDITIONAL INFORMATION

YOUR PHARMACY: ____________________ PHONE# (   ) ____________

RESPONSIBLE PARTY: ❑ SELF ❑ SPOUSE ❑ PARENT ❑ PARTNER NAME ____________

INSURANCE INFORMATION

ALL INFORMATION MUST BE COMPLETED OR WE CANNOT SUBMIT YOUR FEE TO YOUR INSURANCE COMPANY

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder: ____________________	Policy Holder ____________________
Relationship to Patient: ____________DOB________	Relationship to Patient: __________ DOB______
Insurance Co. Name: ____________________	Insurance Co. Name: ____________________
Address: ____________________	Address: ____________________
City: ____________ State ______ Zip ________	City: ____________ State ______ Zip ______
ID# ____________ Group# ____________	ID# ____________ Group# __________

I hereby authorize Perry L. Kamel, M.D., S.C. to furnish information to my insurance carriers concerning my treatments and illness, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependants. **I understand that I am responsible for any amount not covered by my insurance(s).**

SIGNATURE____________________________ DATE____________________
(Patient and/or guardian, if minor)

*Please complete this registration form and **fax** or **mail** back with a **copy of the front and back of your insurance card as soon as possible**. For office visits, we **validate parking for $11.30.** Please park at 222 East Huron, The Northwestern Memorial Hospital Garage, and bring your ticket with you to the office. Discount parking is also available at 161 East Chicago, which is within the building. **It is $13 for 2 hrs. and $15 for 4 hrs**. You pay at the parking garage, but you need to bring your ticket with you to the office to be stamped.*

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FINANCIAL POLICY

Your insurance statement consists of two parts--a patient portion and an insurance portion. When an insurance company is responsible for medical services, you are responsible only for the patient portion. However, when an insurance carrier delays, or withholds payment, both the insurance and the patient portion become your responsibility.

In the absence of insurance carrier payment, our office policy is to bill your credit card for payment in full. We will do our best to work with all insurance carriers.

When your account has gone beyond a 90-day limit, it is extremely important that you speak with your insurance carrier concerning payment. If the insurance carrier eventually pays for medical services, we will refund the charges we have made on your credit card.

Send To: Perry L. Kamel, M.D., S.C.
737 North Michigan Avenue
Suite 620
Chicago, IL 60611

Credit Card Information (please print):

Name of Card Holder:__________________________ __________________________ ____
Last First MI

Name of Patient: _____________________________ _________________________ ____
Last First MI

Name of Card: ____ VISA ___ MASTERCARD ___ DISCOVER ___ AMERICAN EXPRESS

Card Number: ____

Expiration Date: Month (00) ______ 20_____

Authorized Signature: ____

Home Billing Address: ____

Billing Address (if different): ____

Home Phone: _________________________ Work Phone: _______________________

Cell Phone: ___________________________

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PERRY L. KAMEL, M.D., S.C., FINANCIAL POLICY

ILLINOIS STATE LAW requires insurance carriers to pay claims within 30 days of receipt. Insurance carriers who fail to comply with these state standards are subject to additional requirements and penalties. Many, in fact most, insurance carriers have been very slow in reimbursing physicians for medical services and are therefore not in compliance with these regulations.

Perry L. Kamel, M.D., S.C., has instituted a policy addressing unpaid charges which have been submitted to your carrier. If your account is three (3) months or more past due, it may become your responsibility to pay the remaining portion, which will appear on your patient account statement. We will contact you prior to making a charge to your personal credit card for outstanding balances beyond three months.

If your insurance company forwards payment after you have paid your balance, we will gladly credit your account.

We suggest that you monitor your personal account with us very closely and follow the balance as it ages beyond thirty days, at which time you should call your insurance company and request a "claim status report".

Keep in mind the following points when speaking with the insurance claim manager:

- Identify the date of service for the unpaid claim
- Record and retain the date that you called the insurance company
- Record and retain the name of contact with the insurance company
- Identify and correct the problem causing payment delay
- Verify that the insurance company has the appropriate billing information including:
  – Full name of insured
  – Full address of insured
  – Guarantors name of policy
  – Social security number for the guarantor
  – Correct billing address for your policy
  – Insurance policy number

Ask the claims manager when you can reasonably expect a reimbursement and correction of the problem.

Follow up periodically with the same person to ensure activity occurs on your personal account.

Please complete the credit card information sheet in order to ensure proper continuity of care within our practice. When your insurance carrier is holding or denying payment for medical services rendered, it is best if you call them directly with your concerns and questions.