PATIENT INFORMATION

First Name: _______________ Middle Initial: ___ Last Name: __________________ Date of Birth: __________

Address: _____________________________________ City: ________________ State: _____ Zip: __________

Home Phone:__________________ Cell Phone:__________________ Email: ___________________________

Social Security: ______________________ Preferred Language: ☐ English ☐ Spanish ☐ Other _______________

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Partner ☐ Other______________________________

Race: ☐ Asian ☐ African-American ☐ Caucasian ☐ Native Hawaiian ☐ American Indian ☐ Alaskan Indian ☐ Other Pacific Islander ☐ More than one race ☐ Choose not to disclose ☐ Other ____________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Choose not to disclose

Sex:☐ Male ☐ Female ☐ Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Choose not to disclose

☐ Other _________________________

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't know ☐ Something else

☐ Choose not to disclose

Employer Name: ___________________ Address: ___________________________ Phone: _______________

PARENT / GUARDIAN INFORMATION

Mother's/Guardian's Name: _______________________________________ Birth Date: _________________
Mother's/Guardian's Address: ____________________________ City: ____________ State: ____ Zip: _______
Phone: _______________________________ Social Security: _____________________________________
Mother's/Guardian's Employer Name: ___________________________ Employer Phone: ________________
Employer Address: ________________________________ City: _________________ State:____ Zip: _______

Father's/Guardian's Name: ___________________________________ Birth Date: _______________________
Father's/Guardian's Address: _________________________ City: ______________ State: _____ Zip: ________
Phone: ______________________________ Social Security: _____________________________________
Father's/Guardian's Employer Name: _________________________ Employer Phone: __________________
Employer Address: ______________________________ City: _________________ State:_____ Zip: ________

How you hear about us? ☐ Friend/ Family ☐ Advertisement ☐ Medical office ☐ School ☐ Other _____________

Legacy Medical Care Inc. may call the phone number provided to remind you of your appointments, follow-ups, and when the patient is in need of an appointment. ☐ Yes ☐ No

Preferred Pharmacy Name: __________________________ Phone Number: __________________________

Pharmacy Address: ____

Legacy Medical Care has consent to obtain prescription history. ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Names of individuals and relationship to the patient whom I give authorization to contact and give full medical information in case of an emergency.

Primary Emergency Contact: ____________________________ Relationship to Patient: ____________________
Cell Phone: ___________________ Home Phone: ____________________ Work Phone: _________________

Secondary Emergency Contact: _________________________ Relationship to Patient: ____________________
Cell Phone: ___________________ Home Phone: _________________ Work Phone: ____________________

PATIENT INSURANCE COVERAGE

Is the patient self-pay? ☐ Yes ☐ No

Primary Type of coverage: ☐ Medicaid ☐ Medicare ☐ PPO ☐ HMO

Patient Primary Insurance Name: ______________________________________ Effective Date: _____________

Member ID Number: _____________Group Number: _____________Responsible Party: _________________

Company Address: _______________________________________ City: ____________ State: _____ Zip: _____

Secondary Type of coverage:☐ Medicaid ☐ Medicare ☐ PPO ☐ HMO

Patient Secondary Insurance Name: __________________________________ Effective Date: ______________

Member ID Number: _____________Group Number: _____________Responsible Party: _________________

Company Address: ______________________________________ City: ___________ State: ______ Zip: ______

Household Income:

☐ Less than $12,140 ☐ $12,141-$18,210 ☐$18,211-$24,280 ☐ More than $24,281 ☐ Don't Know

Number of household dependents: ___________

Is the patient homeless? ☐ Yes ☐ No

I hereby assign, transfer, and set over to Legacy Medical Care Inc. all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by the insurance.

Parent/Guardian Signature: ____ Date: __________________

Patient Signature: ____ Date: _________________

After Hours Care

If you have a medical problem that needs immediate attention, please call our clinics at any time of the day. If our clinics are closed, a provider will be paged immediately to help you.

Clinic Location:	Clinic Phone Number:
Addison OB/GYN:	(630) 705-1010
Addison Pediatrics and Family :	(630) 599-5400
Arlington Heights OB/GYN:	(847) 749-2248
Arlington Heights Pediatrics and Family:	(847) 749-2248
East Dundee:	(847) 844-3274
Elgin OB/GYN:	(847) 531-8430
Elgin Pediatrics and Family:	(847) 531-8430
Hanover Park OB/GYN:	(630) 705-1010
Hanover Park Pediatrics:	(630) 830-5926

The provider will ask you about your medical problem to decide if you need to:

- See a doctor immediately
- Go to an emergency room
- Stay at home and follow the provider's advice

Emergencies

If you or a family member has any of the following symptoms, immediately dial 911 or go to the nearest Emergency Room:

- Chest pain
- Coughing up or vomiting blood
- Difficulty breathing and/or shortness of breath
- Asthma attack
- Head injury, loss of consciousness, severe headaches
- Sudden confusion, weakness, dizziness, numbness, difficulty speaking
- Suicidal or homicidal behavior or thoughts
- Any other life threatening emergencies or serious injuries