DANIEL S. TRESLEY M.D.

PATIENT INFORMATION

Today's Date: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Gender: M F Marital Status: M S W D Height: _____ Weight: _____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Email: _____ Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Skilled Nursing Care Facility: _____ Phone Number: _____

PHYSICIANS INFORMATION

Referring Physician	**Phone #**
Address	
Primary Physician	**Phone #**
Address	
Referring Patient	**Phone #**

MEDICAL HISTORY

NAME	DOB	DATE
CHIEF COMPLAINT (Reason you came to the doctor)		
BRIEF HISTORY OF PRESENT ILLNESS/CONDITION		
LIST WHEN AND HOW YOUR CONDITION STARTED		
ASSOCIATED SYMPTOMS		

SOCIAL HISTORY

OCCUPATION:

SMOKING ☐ NO ☐ YES Pack per Day _____ How Long _____ Quit Date _____

ALCOHOL USE: ☐ NONE ☐ RARE ☐ OCCASIONALLY ☐ FREQUENT

SURGICAL HISTORY (Past Surgeries with Dates)

COSMETIC:	MEDICAL:

Surgical Complications: ANESTHESIA PROBLEMS ☐ YES ☐ NO

Explain:_____

PAST MEDICAL HISTORY

BREAST CANCER	☐ YES ☐ NO	HIV/ AIDS	☐ YES ☐ NO
BLEEDING TENDENCY	☐ YES ☐ NO	KIDNEY	☐ YES ☐ NO
DIABETES	☐ YES ☐ NO	LIVER DISEASE	☐ YES ☐ NO
HEART DISEASE	☐ YES ☐ NO	LUNG DISEASE	☐ YES ☐ NO
HEART MURMUR	☐ YES ☐ NO	MENTAL ILLNESS	☐ YES ☐ NO
HEPATITIS A, B OR C	☐ YES ☐ NO ☐ A ☐ B ☐ C	NEUROLOGIC DISEASE	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	OTHER CANCER	☐ YES ☐ NO
HISTORY DVT/PE	☐ YES ☐ NO	SKIN CANCER	☐ YES ☐ NO
		THYROID DISEASE	☐ YES ☐ NO

FAMILY HISTORY (indicate which Blood Relative)

SKIN CANCER	HEART DISEASE/STROKE	ABNORMAL BLEEDING
OTHER CANCER	MALIGNANT HYPOTHERMIA	OTHER

REVIEW OF SYMPTOMS:

Fever / Chills:	☐ Yes ☐ No	Bleeding Tendency:	☐ Yes ☐ No
Stomach Ulcer:	☐ Yes ☐ No	Difficulty Swallowing:	☐ Yes ☐ No
Night Sweats:	☐ Yes ☐ No	Allergies:	☐ Yes ☐ No
Reflux:	☐ Yes ☐ No	Speech Changes:	☐ Yes ☐ No
Vision Loss:	☐ Yes ☐ No	Enlarged Thyroid/Goiter:	☐ Yes ☐ No
Back/Neck Pain:	☐ Yes ☐ No	High Blood Pressure:	☐ Yes ☐ No
Double Vision:	☐ Yes ☐ No	Enlarged Gland/Node:	☐ Yes ☐ No
Nerve Pain/Paralysis:	☐ Yes ☐ No	Chest Pain or Tightness:	☐ Yes ☐ No
Dry Eye:	☐ Yes ☐ No	Frequent Sunburns:	☐ Yes ☐ No
Facial Weakness:	☐ Yes ☐ No	Asthma/Breathing Problems:	☐ Yes ☐ No
Nasal Obstruction:	☐ Yes ☐ No	Scarring/Keloids:	☐ Yes ☐ No
Depression/Anxiety:	☐ Yes ☐ No	Shortness of Breath:	☐ Yes ☐ No
Difficulty Urinating:	☐ Yes ☐ No	Renal Failure/Dialysis:	☐ Yes ☐ No
Drug or Alcohol Dependency	☐ Yes ☐ No	Breast Mass/Lump:	☐ Yes ☐ No
Sinus Problems:	☐ Yes ☐ No	Hepatitis/Jaundice:	☐ Yes ☐ No

FEMALE PATIENTS

Are you currently pregnant? ☐ Yes ☐ No

CURRENT MEDICATIONS

Please list dosage and schedule ☐ See List ☐ None

1.	4.
2.	5.
3.	6.

ARE YOU CURRENTLY TAKING OR HAVE TAKEN WITHIN THE LAST 14 DAYS ANY OF THE FOLLOWING BLOOD THINNG MEDICATIONS?

ASPIRIN:	☐ YES ☐ NO	IBUPROFEN:	☐ YES ☐ NO	HOMEOPATHIC:	☐ YES ☐ NO
SBE PROPHYLAXIS:	☐ YES ☐ NO	ADVIL:	☐ YES ☐ NO	ALEVE:	☐ YES ☐ NO
BABY ASPIRIN:	☐ YES ☐ NO	ARTHRITIS MEDICATION:	☐ YES ☐ NO	COUMADIN:	☐ YES ☐ NO
VITAMIN E:	☐ YES ☐ NO	PAIN MEDICINE:	☐ YES ☐ NO		

Steroids in the last 12 months: ☐ Yes ☐ No
Do you take a Blood Thinner? ☐ Yes ☐ No Medication Name: _____

ALLERGIES TO MEDICATIONS: ☐ YES ☐ NO IF SO, PLEASE LIST BELOW.

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: ☐ Penicillin ☐ Lidocaine ☐ Latex ☐ Tape

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING EYE CONDITIONS:

CATARACTS ☐YES ☐NO **GLAUCOMA** ☐YES ☐NO **DRY EYES** ☐YES ☐NO **MACULAR DEGENERATION** ☐YES ☐NO

GUARANTOR INFORMATION

(The guarantor is the responsible party for insurance payments and charges.)

☐ **CHECK HERE, IF SAME AS PATIENT INFORMATION**	
GUARANTOR NAME	**SSN**
RELATIONSHIP TO PATIENT	OCCUPATION
HOME ADDRESS	
CITY, STATE, ZIP	
BUSINESS NAME	EMPLOYER
BUSINESS ADDRESS	
CITY, STATE, ZIP	
HOME PHONE	BUSINESS PHONE

CONSENT TO PHOTOGRAPHS

I, _____ (print full name) understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Daniel S. Tresley M.D. the right to decline my treatment. I consent to the taking of photographs by Dr. Tresley, or his assistant of me in connection with the procedure(s) to be performed by Dr.Tresley.

I grant Dr. Tresley the right to use photographs of me, in the following areas: (initial all/any for use)

_____ All
_____Website for Consumers
_____Newsletter to be sent to patients
_____Practice brochures
_____Public relations material
_____Seminars
_____Patient before and after photo information sheets
_____ **Chart only, not for use in advertising material**

☐ **Check Box to refuse to release photograph documentation.**

If in the judgment of my physician, medical research, education or science will benefit by their use, the photographs and information relating to my case maybe published and republished in professional journals and medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research. I understand that in any such publication or use I shall not be identified by name. I understand that I may refuse to authorize the release of any photo documentation and that my refusal to consent to the release of photo documentation will prevent the disclosure of such information, but will not affect the healthcare services I presently receive, or will receive.

I understand that by signing below that Dr. Daniel Tresley need not approach me again for authorization on these photos.

_____ _____
Patient Signature Date

INSURANCE POLICY:

Patients with private healthcare insurance:
The private healthcare insurance presented at the time of your visit will be billed for your treatment, HMO patients will need to start the process of securing a referral. Every effort will be made to ensure that claims are promptly and correctly submitted to your insurance company. Your insurance company has 30 days after receiving a correctly filed claim to process, pay and/or give notice as to why the claim has not been paid. After that time the remaining balance will be your responsibility. If you are not satisfied with the payment made by your insurance company, contact them directly at the phone number listed on your insurance card. If you chose to appeal to your insurance company in writing for additional payment please provide Daniel S. Tresley, M.D. with a copy of that appeal for your file.

Patients with Worker's Compensation or Automobile Accident Insurance:
If your injury was received as a result of a motor vehicle accident or a liability and you do have private healthcare insurance, typically your private healthcare insurance will not make payments on your medical claims without a written denial from your motor vehicle insurance/liability insurance. It is very important that al pertinent information be given at the time of your visit regarding the motor vehicle insurance/liability insurance, including claim number, agent information, claim billing address, accident report, etc.

Name of Insurance Company: _____

Agent/Representative: _____ Phone Number: _____

Address: _____ City: _____State:_____ Zip: _____

CASE/CLAIM #: _____ Date of Injury: _____

Patients without private healthcare insurance – Self Pay:
If not private healthcare insurance is presented at the time of your visits, full payment or an approved payment plan is expected at the time of service.
_____Patient initials

Patients with Illinois Department of Public Aid – IDPA (MEDICAID):
IDPA is not accepted at Daniel S. Tresley, M.D. Full payment or an approved payment plan is expected at the time of service.
_____Patient initials

FOR ALL PATIENTS:

- Any insurance policy is a contract between you and your insurance company.
- It is your responsibility to verify, with your insurance company, if a provider is in or out of network for your plan.
  Patient initials _____
- Any unpaid balance left by your insurance company will be your responsibility.
  Patient initials _____
- Insurance benefits paid directly to the patient will need to be forwarded to Daniel S. Tresley, M.D. to keep the account in good standing.
- If you have retained an attorney regarding your injury, it is very important to provide Daniel S. Tresley, M.D. with that information.
- Payment plans can be established with the approval of the billing department 847-770-6660.
- Cash, checks and all major credit cards are accepted for payment.
- You can contact the billing department with any questions.

CREDIT CARD PAYMENT SYSTEM:

In order to facilitate our billing process, Daniel S. Tresley, MD has implemented a Credit Card payment system. Our goal is to assist our patients in eliminating past due patient accounts.

Your credit card information will be held *securely on file until your Insurance Company has paid your claim*. Once your "Explanation of Benefits" has been filed, any remaining balance owed by you "patient responsibility", will be charged to the credit /debit card we have on file. A copy or receipt of those charges will then be mailed to you.

The advantage to you is that you will no longer need to write out checks and send payments in mail. You will also not have to worry about any past due accounts.

This in no way will compromise your ability to dispute charges or question your insurance company's determination of payment. All credit card contracts give card holders the right to challenge any charges against an account.

Name on Card_____

Patient name_____

Visa _____ MasterCard_____ Discover _____

***Last 4 Account #_____Expiration_____ CVV #_____

Signature_____

Our goal is to provide you with the highest quality of care while keeping the cost of medical care low. Thank you for your assistance.

*****Card will be swiped, encrypted and securely saved on file for your convenience*****

FINANCIAL POLICY:

I HEREBY AUTHORIZE Daniel S. Tresley, M.D. to release to my insurance company any information acquired in the course of my examination or treatment and authorize benefits to be paid directly to Daniel S. Tresley, M.D. I understand I am responsible for any unpaid balance or charges not covered by my insurance plan. I also agree to pay for all additional costs if my account is turned over to a collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees in an effort to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, and collection services.

Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

H I P A A

I, _____have been informed that a copy of our office's Notice of Privacy Practices is available. upon request.

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, and cell phone. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone /voicemail	yes____ no ____
Cell phone/voice mail	yes____ no____
Work phone	yes____ no____
May we fax medical records for referrals?	yes____ no____

I hereby authorize Daniel S. Tresley, MD to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other healthcare providers, laboratories, radiology facilities or other institutions.
This authorization remains in effect until revoked.

_____ _____
Signature of Patient Date

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____ Relationship to patient: _____

Phone (cell):_____ Phone (work) _____ext._____ Phone (home):_____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Please list names of people we can discuss your medical or cosmetic care with:

	Relationship	
Spouse Name _____	_____	yes____ no____
Parent Name _____	_____	yes____ no____
Other Name _____	_____	yes____ no____

Please give name and relationship such as boyfriend, sister, parent etc.