PATIENT REGISTRATION FORM

Patient's SSN:_____
Patient's Name:_____ Date of Birth:_____ Male Female
Address:_____ Phone: (___)_____Cell: (___)_____
City/Town:_____ State:_____ Zip Code:_____

If *Minor*, Name of Parent/Guarantor:_____
Billing Address, If not as above:_____
City/Town:_____ State:_____ Zip Code:_____

Patient's Relationship to Insured:_____
Referral Source:_____ Family M.D._____

HEALTH INSURANCE CLAIM INFORMATION

Insured's Name:_____ Insured's SSN:_____
Insured's Employer:_____ Phone: (_____)_____
Employer's Address:_____
City/Town:_____ State:_____ Zip Code:_____
Insured's Insurance Compnay:_____
Insured's Date of Birth:_____
Insured's Group #:_____ Contract/Certificate #:_____Co-pay Amt:_

Is there another health benefit plan? (Circle) Yes No *If yes, complete items for SECONDARY insurance.*

Secondary Insured's Name:_____ Secondary Insured's SSN:_____
Secondary Insured's Employer:_____ Phone: (_____) _____
Secondary Employer's Address:_____
City/Town:_____ State:_____ Zip Code:_____
Secondary Insurance Company:_____
Secondary Insured's Date of Birth:_____
Secondary Insured's Group #:_____Contract/Certificate #:_____Co-pay Amt:_

Payment is expected at the time of service unless previous arrangements have been made.
Also, you will be financially responsible if a referral is needed for your visit and you have failed to provide it at time of service.

I authorize the release of any medical information necessary to process this claim & payment of medical benefits to Diane L. Ozog, M.D., S.C.

Signed_____ Date:_____

Diane L. Ozog, M.D., S.C. / 1331 W. 75th Street Suite 303 / Naperville, IL 60540 – 630-652-0606

Retail Pharmacy: _____ City: _____ Phone: _____
Mail Order Pharmacy: _____ City: _____ Phone: _____

Chart # & Physician Initials: _____

EMAIL: _____

DIANE L. OZOG, M.D., S.C.
Adult & Pediatric Allergy, Immunology & Asthma
Telephone: 630-652-0606 Fax Number: 630-652-9900

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PATIENT INFORMATION SHEET

Patient Name:_____ Today's Date:_____

Birth Date:_____

Primary Physician:_____

Primary Physician Address & Phone Number:_____
_____
_____
_____

List Current Medications Taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

List Medical Problems or Surgeries Since Last Office Visit:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies:

Medications: Yes No Please List:_____
_____
_____

Foods: Yes No Please List_____
_____
_____

Other: Yes No Please List_____
_____
_____

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Patient Name:_____ Today's Date:_____

Do You Have Any Household Pets?: Cat Dog Bird Other:_____

Do You Drink? Yes No How Much Per Week? _____

Do You Smoke? Yes No If yes, please indicate: Cigarettes Cigars Pipe
For How Long? _____ How Much Per Day? _____
Any Household Smokers? Yes No Who? _____

Do You Use Recreational/Street Drugs? Yes No If yes, what?_____

Do You or Your Family Have Any History of:

	Self		Family		Which Relative?
Asthma	Yes	No	Yes	No	_____
Lung Disease	Yes	No	Yes	No	_____
Heart Problems	Yes	No	Yes	No	_____
Diabetes	Yes	No	Yes	No	_____
Stroke	Yes	No	Yes	No	_____
High Blood Pressure	Yes	No	Yes	No	_____
Cancer	Yes	No	Yes	No	_____
Thyroid Disease	Yes	No	Yes	No	_____
Gastrointestinal Disease	Yes	No	Yes	No	_____
Kidney Disease	Yes	No	Yes	No	_____
Neurological Disease	Yes	No	Yes	No	_____
Anxiety or Depression	Yes	No	Yes	No	_____
Eczema or Skin Problems	Yes	No	Yes	No	_____
Immunodeficiencies or Autoimmune Disease	Yes	No	Yes	No	_____

DIANE L. OZOG, M.D., S.C.

1288 Rickert Drive – Suite 100 Naperville, Illinois 60540
Phone: 630-652-0606 Fax: 630 652-9900

CONSENT FOR TREATMENT
ASSIGNMENT OF BENEFITS

I, _____,on behalf of myself and/or my child_____, hereby present for health care services to be rendered by Diane L. Ozog, M.D., S.C. and hereby consent to the same. I understand that by my signature below, I do authorize and consent to the performance of all tests, procedures, treatments and/or teaching of medical devices which may be ordered by my physician or at the direction of my physician and I consent to such treatments and procedures as may be carried out by members of the medical staff and other health care providers at Diane L. Ozog, M.D., S.C. I have been informed that in receiving care and treatment at Diane L. Ozog, M.D., S.C., I may receive care and treatment from my selected attending physician, his or her partners, colleagues and associates, nurses, ancillary staff and interns or residents who may be based in the office on a temporary basis for training purposes.

I understand that the practice of medicine is not an exact science. I further acknowledge that no guarantees have been made to me as to the results or outcomes that may be obtained through care and treatment at Diane L. Ozog, M.D., S.C.

x_____ _____ _____ _____
Patient/Parent/Legal Guardian Date Witness Date

Acknowledgement and/or Receipt of Notice of Privacy Practices

I have received and been presented with the opportunity to review Diane L. Ozog, M.D.,S.C.'s Privacy Notice. The Notice or Privacy Practice provides detailed information about how the practice may use and disclose my confidential protected health information. I do hereby authorize the use and disclosure of my protected health information, including my medical records, test results and other information necessary for treatment, payment or health care operations.

x_____ _____ _____
Patient/Parent/Legal Guardian Date Relationship to Patient Formal Name only

Assignment of Benefits and Payment Agreement

I hereby certify that I am the patient or duly authorized general agent of the patient authorized to furnish all information concerning responsibility for payment, insurance information and assignment of benefits. I understand that Diane L. Ozog, M.D., S.C. requires that payment is due at the time of service, unless prior arrangements have been made. I also understand that copays and deductibles are due at the time of the visit. I understand that even though I may have insurance coverage for health care I am personally responsible for full payment of all services rendered by Diane L. Ozog, M.D., S.C. I understand that some tests, procedures, treatments and teaching services may or may not be covered by my insurance company. I have been informed and understand that as a courtesy to me, Diane L. Ozog, M.D., S.C. will file my claim with my insurance company pursuant to the assignment of benefits I authorize by my signature below.

If my insurance company does not pay Diane L. Ozog, M.D., S.C. within a reasonable time period, I understand I will be responsible for payment in full. I further agree to be personally responsible for payment, in full, for any services not otherwise covered and paid for by insurance. I agree to pay for all services rendered and not otherwise covered by insurance, in full, within thirty (30) days of receiving a bill form Diane L. Ozog, M.D., S.C. In the event that my account becomes delinquent for a period beyond sixty (60) days, I hereby acknowledge that I will be immediately responsible for the balance, interest, costs of collection and reasonable attorneys fees. I hereby authorize release of information necessary to file a claim with my insurance company and to assign any benefits payable be made on my behalf to Diane L. Ozog, M.D., S.C., including but not limited to employment verification and credit reporting from a Consumer Reporting Agency as may be necessary. I request that payment of authorized Medicare benefits be made on my behalf to Diane L. Ozog, M.D., S.C. for services furnished to me. I authorize the holder of medical information about me to release to CMS or other appropriate governmental agency and their agents, any information needed to determine benefits or benefits payable for related services.

I have read the financial policy for Assignment of Benefits and Payment Agreement and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

x_____ _____ _____

Signature of Patient/Guarantor/Guardian Date Printed Name of Patient

DIANE L. OZOG, M.D.,S.C.

1288 Rickert Drive - Suite 100
Napeville, Illinois 60540
Phone: 630-652-0606 Fax: 630-652-9900

Missed Appointment/Cancellation Policy

As of January 1, 2009, all patients who fail to arrive for their scheduled appointments or do not cancel within 24 hours will be charged a missed appointment/cancellation fee of $50. This fee applies to all patients, regardless of their insurance status or insurer. Reminder: phone calls are a courtesy, and the lack of receipt of a reminder call is not a valid excuse for missed appointments. Missed appointment/cancellation fees are NOT covered by insurance, and will be the patient's personal responsibility to pay. (Pursuant to CMS 10/1/07)

I, _____, have read the above statement and understand that I will be charged a fee of $50 for any missed appointment/late cancellation. I am aware that my insurance will not cover this charge and that I am personally responsible for the fee.

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
Patient/Guarantor Signature Date Signed

_____
Relation to Patient if other than self

Revised 06-16-26