



# The Ayre Clinic for Contemporary Medicine

11S250 Jackson Street, Suite 101, Burr Ridge IL 60527 / 630-321-9010 / fax: 630-321-9018 / www.contemporarymedicine.net

## PATIENT INFORMATION

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LAST NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
 FIRST NAME \_\_\_\_\_ MARITAL STATUS S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_  
 ADDRESS \_\_\_\_\_ GENDER F \_\_\_\_\_ M \_\_\_\_\_  
 CITY \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL (OPTIONAL) \_\_\_\_\_

### PATIENT EMPLOYMENT INFORMATION

EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_

### YOUR PHARMACY

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

### HOW DID YOU LEARN ABOUT CONTEMPORARY MEDICINE?

- |   |  |
|---|--|
| <input type="checkbox"/> Physician Referral     | <input type="checkbox"/> Advertisement             |
| <input type="checkbox"/> Internet               | <input type="checkbox"/> Newsletter                |
| <input type="checkbox"/> Friend or Acquaintance | <input type="checkbox"/> Book or other Publication |

## ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that the signature on this document authorizes my physician to submit claims for benefits, services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by my signature as through the undersigned had personally signed the particular claim.

I \_\_\_\_\_ hereby authorize my insurance company to pay and

Print Name of Insured

hereby assign directly to \_\_\_\_\_ **The Insured** \_\_\_\_\_ all benefits, if any. I understand that I am financially responsible for all charges incurred.

\_\_\_\_\_  
 Authorized Signature of Insured or Legal Representative

\_\_\_\_\_  
 Date

**THE AYRE CLINIC FOR CONTEMPORARY MEDICINE**  
11S250 JACKSON STREET, SUITE 101, BURR RIDGE IL 60527

**INSURED INFORMATION**

PERSON WITH INSURANCE

- SELF                       PARENT                       NO INSURANCE  
 SPOUSE                       OTHER

INSURED'S LAST NAME \_\_\_\_\_ SS# \_\_\_\_\_

INSURED'S FIRST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

☞ Please fill out the section below *ONLY IF THE INSURED PERSON IS DIFFERENT THAN THE PATIENT* ☞

INSURED'S LAST NAME \_\_\_\_\_ SS# \_\_\_\_\_

INSURED'S FIRST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

INSURED'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

NAME OF INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

ID OR POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

NAME OF INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

ID OR POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

# Contemporary Medicine

## Health History Questionnaire

Date: \_\_\_\_\_

Name \_\_\_\_\_ D.O.B. \_\_\_ / \_\_\_ / \_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Past Medical History** (conditions & dates) \_\_\_\_\_

**Past Surgical History** (procedures & dates) \_\_\_\_\_

**Family History** - Heart disease \_\_\_ Cancer \_\_\_ Diabetes \_\_\_ Tuberculosis \_\_\_ Others \_\_\_\_\_

(Please provide relevant details below: - living - deceased - age/age at death - conditions)

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_

**Personal History** - Occupation \_\_\_\_\_ Relationship status - S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

Spouse's Occupation \_\_\_\_\_ Children: M/Ages \_\_\_\_\_ F/Ages \_\_\_\_\_

Smoker Y \_\_\_ N \_\_\_ Ex-Smoker Y \_\_\_ N \_\_\_ Smoking History: \_\_\_cigs/day X \_\_\_ yrs. Alcohol \_\_\_ounces/week

Coffee/Tea \_\_\_ cups/day Pop \_\_\_ cans/day Do you feel you eat a well balanced diet most of the time? Y \_\_\_ N \_\_\_

Medications and Dosages: \_\_\_\_\_

Supplements & etc. \_\_\_\_\_

Allergies: Medications \_\_\_\_\_ Foods \_\_\_\_\_ Inhalants & etc. \_\_\_\_\_

**Symptom Inventory:** - For all of the following that apply to you, please indicate whether your symptoms are:

**Mild (1) - Moderate (2) - or Severe (3)**

hair loss \_\_\_ skin rashes \_\_\_ (itchy \_\_\_ hands \_\_\_ feet \_\_\_ trunk \_\_\_ perineum/crotch \_\_\_) easy bruising \_\_\_  
visual disturbances \_\_\_ (blurred \_\_\_ see bright lights \_\_\_) itchy eyes \_\_\_ earaches \_\_\_ reduced hearing \_\_\_  
buzzing in ears \_\_\_ sinus pain \_\_\_ nose bleeds \_\_\_ runny nose \_\_\_ nasal obstruction/mouth breathing \_\_\_ sore tongue \_\_\_  
sore gums \_\_\_ pressure/temperature sensitive teeth \_\_\_ clicking of jaw \_\_\_ orthodontic braces \_\_\_ tooth extractions \_\_\_  
root canals \_\_\_ dentures \_\_\_ frequent sore throats \_\_\_ hoarseness \_\_\_ ulcers/sores in mouth \_\_\_ cold sores \_\_\_  
stiff/sore neck \_\_\_ shortness of breath \_\_\_ (on exertion \_\_\_ lying down \_\_\_) cough \_\_\_ (with sputum \_\_\_ or with blood \_\_\_ )  
wheezing \_\_\_ snoring \_\_\_ chest pain \_\_\_ average times per week \_\_\_ (on exertion \_\_\_ at rest \_\_\_ ) palpitations \_\_\_ cold  
hands/feet \_\_\_ pain in calves after walking \_\_\_ swelling of ankles \_\_\_ fainting spells \_\_\_ dizzy spells \_\_\_ varicose  
veins \_\_\_ loss of appetite \_\_\_ difficulty swallowing \_\_\_ heartburn \_\_\_ "sour hiccups" \_\_\_ nausea \_\_\_ vomiting \_\_\_  
weight gain \_\_\_ weight loss \_\_\_ abdominal pain \_\_\_ abdominal bloating \_\_\_ burping \_\_\_ passing gas \_\_\_ diarrhea \_\_\_  
constipation \_\_\_ blood in stools \_\_\_ hemorrhoids \_\_\_ hernias \_\_\_ frequent bladder infections \_\_\_ incontinence \_\_\_  
(spontaneous \_\_\_ with coughing/sneezing \_\_\_ ) get up at night to urinate \_\_\_ (# \_\_\_) decrease in force/flow \_\_\_  
discharge \_\_\_ back pain \_\_\_ arthritic pains \_\_\_ (where \_\_\_\_\_)  
difficulty sleeping \_\_\_ panic attacks \_\_\_ depression \_\_\_ headaches \_\_\_ memory loss \_\_\_ frequent loss of  
temper \_\_\_ numbness/tingling \_\_\_ (where? \_\_\_\_\_) fatigue \_\_\_ dizziness \_\_\_ balance problems \_\_\_  
other symptoms not listed? \_\_\_\_\_

\* **For women** \* menstrual periods - regular \_\_\_ irregular \_\_\_ pain/cramps \_\_\_ days of flow \_\_\_ length of cycle \_\_\_  
date of last menstrual period \_\_\_\_\_ pain or bleeding during or after intercourse \_\_\_\_\_

Are you presently using some form of birth control? Y \_\_\_ N \_\_\_ Which one? \_\_\_\_\_ For how long? \_\_\_\_\_

Any other previous form of birth control? Y \_\_\_ N \_\_\_ Which one? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever been on BCPs? Y \_\_\_ N \_\_\_ For how long? \_\_\_\_\_ When? \_\_\_/\_\_\_ to \_\_\_/\_\_\_ (approx.)

How many pregnancies? \_\_\_ how many live births? \_\_\_ any miscarriages or abortions? \_\_\_

**Recent Stress History** - In the past 12 months, have you experienced any of the following major stresses?

marriage \_\_\_ divorce \_\_\_ death of a spouse \_\_\_ other death in the family \_\_\_ loss of or change of job \_\_\_ moving your  
place of residence \_\_\_ significant financial loss \_\_\_ significant financial gain \_\_\_ automobile accident \_\_\_ hospitalization \_\_\_

## Consent for Release of Medical Records

Date \_\_\_\_\_

Physician/Institution \_\_\_\_\_

Address \_\_\_\_\_

I hereby request transfer of portions of my medical records, as specified below to:

**The Ayre Clinic for Contemporary Medicine**  
**Thomas L. Hesselink, MD**  
**11S250 Jackson Street, Suite 101**  
**Burr Ridge, IL 60527**  
**ph: 630-321-9010 fax: 630-321-9018**

Admission Hx and Px

MRI Printed Reports

Hospital Discharge Summary

X-Ray Printed Reports

Typed Consultations

CT/PET Printed Reports

Pathology Reports

Tumor Markers

Other \_\_\_\_\_

Mammogram Reports

Records will include all materials from the following dates: \_\_\_\_\_

### Reason for release

Continuing Care

Change of Insurance

Referral

Other \_\_\_\_\_

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date of Birth

*This release will expire within one year of being signed*

## OUR FINANCIAL POLICY

Thank you for choosing Contemporary Medicine as your health care provider. The following is a statement of our Financial Policy, which we require you read and sign prior to your treatment.

***We require payment at the time of service for medical care provided to you.*** You are responsible for payment regardless of your insurance provider's determination of usual and customary rates. All services provided through Contemporary Medicine are considered out-of-network services. We do not submit claims to Medicare.

As a courtesy to you, we will submit all charges to your insurance provider. Any and all insurance benefits resulting from these claims will be assigned to you. It is possible to receive out-of-network reimbursement, depending on your plan and coverage. We cannot make any guarantees of reimbursement.

For your convenience, we accept personal checks, VISA, MASTERCARD, and DISCOVER.

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*I hereby declare that I have read the Financial Policy and understand and accept all of the above statements:*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_