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?

- ☐ Physician Referral
- ☐ Internet
- ☐ Friend or Acquaintance
- ☐ Advertisement
- ☐ Newsletter
- ☐ 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
- ☐ Hospital Discharge Summary
- ☐ Typed Consultations
- ☐ Pathology Reports
- ☐ Other _____
- ☐ MRI Printed Reports
- ☐ X-Ray Printed Reports
- ☐ CT/PET Printed Reports
- ☐ Tumor Markers
- ☐ Mammogram Reports

Records will include all materials from the following dates: _____

Reason for release

- ☐ Continuing Care
- ☐ Referral
- ☐ Change of Insurance
- ☐ 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.

Dr. Hesselink has opted out of Medicare. Under the terms of the Medicare Private Contract. Neither you nor Contemporary Medicine may submit claims to Medicare. Claims may be sent to a secondary insurance provider (not supplementary) for processing.

The lab (Healthlab) that we use will submit charges to your insurance plan for processing of any blood work or other medical testing that we perform through this facility.

All claims related to charges billed through Contemporary Medicine can be submitted by you or an outside billing service company. We can furnish you with information on possible billing services.

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: _____