

***Kankakee Valley OB/GYN, LLC***

375 N. Wall Street, Suite P630  
Kankakee, Illinois 60901  
(815) 933-4510 Fax (815) 933-4259

Dear \_\_\_\_\_

You have been scheduled for an appointment on \_\_\_\_\_ with Dr. Haile/Dr. Mehta or Nikki Nettgen, CNM. We are forwarding registration forms to you, please complete the forms the best you can and bring them with you at the time of your appointment. Please be sure to bring your insurance card with you for your appointment.

Out of respect for our patients and our physicians, we do not allow children into the exam area, unless they are in a child carrier or a stroller. Please make prior arrangements for child care. If this is not possible we will ask that you reschedule your appointment.

If you bring someone with you for your appointment, please limit it to only one person. If others need to come with you to attend other physicians appointments, we ask that they wait in the solarium on the 6<sup>th</sup> floor by the elevators or in the lobby of the Pavilion Building on the 1<sup>st</sup> floor.

Our office is located in the new Pavilion Building directly across the street from Riverside Medical Center at 375 N. Wall street, Suite P630. For your convenience there is a new parking garage located next to the new building and also outdoor parking adjacent to the building.

If you are unable to make your appointment, please call us at least 24 hrs in advance.

Kankakee Valley OB/GYN, LLC

(Patient, parent, or guardian)

Signature

Date

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I certify that the information I have reported with regard to my insurance coverage is correct.

I hereby authorize KVOB to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to KVOB / or to the party who accepts assignment).

KVOB

to apply for benefits on my behalf for covered

Signature

Date

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

INFORMATION AND ASSIGNMENT OF BENEFITS

ID #

Group #

Tel.#

Secondary Insurance Company Name

ID #

Group #

Tel.#

Primary Insurance Company Name

Medicaid # (if applicable)

Medicare # (if applicable)

INSURANCE

Relationship to patient

DOB

Street Address

City / State

Zip

SS

Name

Tel#

INSURED PERSON (IF NOT PATIENT)

Patients occupation

Employer street address

City / State

Zip

Employer name

Tel#

PATIENT EMPLOYER INFORMATION

Emergency contact

Tel#

Relationship

Spouse's employer / address

Spouse's name

Referred by

Telephone: Home

Office

City

Zip

State

Street Address

Date of birth

Marital status: S M W Sep D

Name

SS#

Name

PATIENT REGISTRATION



**PATIENT REGISTRATION**

Name \_\_\_\_\_ SS# \_\_\_\_\_

**GENERAL MEDICAL INFORMATION**

Describe the current medical problem/reason for today's visit: \_\_\_\_\_

Present medications: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: \_\_\_\_\_

Other physicians currently treating you: \_\_\_\_\_

Previous or other medical problems: \_\_\_\_\_

List any previous surgeries or hospitalizations (include number of miscarriages and live births): \_\_\_\_\_

Females only: Are you pregnant, planning a pregnancy or nursing a child?  Yes  No

Do you smoke?  No  Yes  Cigarettes  Pipe  Cigars No. of years \_\_\_\_\_ How much? \_\_\_\_\_

Interested in stopping?  Yes  No

Do you regularly drink alcohol?  Yes  No

How many ounces/beers per day? \_\_\_\_\_

Do you regularly drink coffee?  Yes  No

How many cups per day? \_\_\_\_\_

Are you under a lot of pressure at work?  Yes  No

Please describe: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

Have you ever had any of the following (check all that apply):

Asthma  Chest pain/pressure/tightening

Hypertension  Dizziness spells

Heart attack  Cancer

Stroke  Diabetes

Headaches  Arthritis

Glaucoma  Difficulty hearing

Allergies or Eczema  Anemia

Depression  Memory loss

Blood in stool  Hemorrhoids

Frequent urinary infections

**IMMUNIZATIONS**

Blood transfusion prior to 1992  Tattoos

IV drug use (1+ times)

(Year last received, if known)

Smallpox \_\_\_\_\_

Tetanus \_\_\_\_\_

Typhoid \_\_\_\_\_

Polio \_\_\_\_\_

Influenza \_\_\_\_\_

Pneumonia \_\_\_\_\_

Rubella \_\_\_\_\_

Hepatitis \_\_\_\_\_

High blood pressure

Epilepsy

Cancer

High blood pressure	<input type="checkbox"/>	Father
Epilepsy	<input type="checkbox"/>	Mother
Cancer	<input type="checkbox"/>	Father's Parents
Eczema / Psoriasis	<input type="checkbox"/>	Mother's Parents
Heart attack / Stroke	<input type="checkbox"/>	Father's Parents
Diabetes	<input type="checkbox"/>	Mother's Parents
Asthma	<input type="checkbox"/>	Siblings
Hay fever	<input type="checkbox"/>	Children

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Name