# KIRILL ZHADOVICH, M.D., S.C.

**Dr. Kirill Zhadovich & Dr. Alex Kostiv**
7900 N Milwaukee Ave, Suite 2-24, Niles, IL 60714
Phone: (847) 825-0800 Fax: (847) 825-0803

## PATIENT INFORMATION:

| | | | |
|---|---|---|---|
| **Patient Name:** Last | First | Middle Initial | **Phone:** |
| **Address:** Street | City | State | Zip Code |
| **Birth Date:** | **Social Security Number:** | **Status:** ___Single ___Married ___Divorced ___Widow(er) | |
| **Gender (circle):** M F | **Email Address:** | | **Student Status (circle)** N/A part-time full-time |
| **Patient Employer:** | **Occupation:** | **Status (circle)** part time full time | **Employer Phone:** |

**Highest Level of Education Completed:**
__ Grade School ___ High School/GED ___Trade/Vocational School ___ Associate's ___ Bachelor's ___ Post Graduate

| | | | |
|---|---|---|---|
| **Spouse Name:** Last | First | Middle Initial | **Phone:** |
| **Emergency Contact:** Last | First | Middle Initial /Relationship | **Phone:** |

## INSURANCE INFORMATION(*****if you have provided your insurance cards you may skip this section*****):

| | | | | | |
|---|---|---|---|---|---|
| **Primary Insurance Name:** | | | **Policy Number/Group Number:** | | |
| **Subscriber Name:** Last | First | Middle Initial | **Gender:** | **DOB:** | **Phone:** |
| **Subscriber Address:** Street | City | | State | | Zip Code |
| **Secondary Insurance Name:** | | | **Policy Number/Group Number:** | | |
| **Subscriber Name:** Last | First | Middle Initial | **Gender:** | **DOB:** | **Phone:** |

## CONSENT FOR TREATMENT AND RELEASE OF INFORMATION:

1. I hereby voluntary request, consent to, and authorize my attending physician, his associates, assistants, or other practitioners under orders, or the staff physician who may be assigned by the hospital, his associates, assistants, or other practitioners under his orders to attend me at affiliated hospital, and to provide medical and surgical treatment and hospital care, including but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the care and treatment which I have hereby authorized.

2. I authorize Kirill Zhadovich, M.D., S.C., to release to any third party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, excluding alcohol and drug abuse records protected under regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological services records, if any, including communications made to me by a social worker or psychologist. I also authorize Kirill Zhadovich, M.D., S.C., to release to individuals or agencies which may provide services for my care following hospital treatment, such information from my patient records as is necessary to provide those services. This consent shall be effective only so long as necessary to obtain reimbursement and will expire when reimbursement is obtained or until required third party payer review of necessary records is completed. This consent is subject to revocation at any time with respect to any alcohol or drug abuse records, except to the extent that action has been taken in reliance thereon. If this is an outpatient authorization, I further understand that my treatment may require more than one occasion of service, therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further outpatient treatment. I understand that treatment may be rendered at affiliated hospital.

3. I hereby assign all payments for medical services rendered to myself or my dependents to Kirill Zhadovich, M.D., S.C. I understand that I am responsible for any amount not covered by my insurance. In Medicare cases, Kirill Zhadovich, M.D., S.C. agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. I request that payment of authorized benefits be made on my behalf to Kirill Zhadovich, M.D., S.C.

4. I understand the content and significance of this form, and my questions have been answered.

**Signature of Patient:** _____ **Date:** _____

*Legal Guardian or closet relative may sign for patient if patient is unable to consent or is a minor*

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## Office Policies

- Payment is expected at the time of service. If you have insurance, proper evidence of coverage must be provided. Office copays are due at the time of service.
- The office only accepts payment methods of personal check or cash. credit or debit cards.
- Cancellation of an appointment requires a 24-hour notice. The office reserves the right to charge a $50 fee for missed or cancelled appointments without proper notification.
- Copies of medical records must be picked up in person at the office. We do NOT email, mail, or send medical records to personal faxes. We do offer patients the option to enroll in our patient web portal.
- Follow-up appointments are part of the physician-patient relationship, patients must make and keep regular follow up appointments in order to continue to receive care, such as medication refills, orders, referrals, etc.
- Patients must notify the office of any changes such as changes in insurance coverage, name changes, new residence address, etc.
- Patients are responsible for verifying their own insurance benefits and coverage. Our office may be able to provide a general estimate of coverage/benefits, but ultimately this is the patient's responsibility.
- Our office requires at least 2-5 business days to process insurance referrals and authorizations (including imaging and medications).

*By signing this document, I acknowledge that I have read and understand the policies of this office*

Patient Signature: _____ Date: _____

*If you are NOT the patient, please specify relationship to patient: _____

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## Authorization for Disclosure of Medical Information

In compliance with HIPPA regulations, our office will not disclose ANY medical information pertaining to your record without your written consent. Please provide us with your personal contact information for communicating your medical information (please note, as mentioned, we do NOT mail, email, or send by personal fax any medical information). If you have any other individuals (i.e. spouse, children, family members, friends, etc.) who you would like to authorize access to your medical information, please provide their information as well.

Patient Name (please print): _____ DOB: _____

Primary Phone Number: _____

Is it okay to leave voicemails containing medical information on this phone (circle)? Yes No

Secondary Phone Number: _____

Is it okay to leave voicemails containing medical information on this phone (circle)? Yes No

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### Authorized Contacts:

**(individuals MUST be on this list in order to communicate or receive any of your medical information)**

Contact Name: _____ Relationship: _____

Contact Phone Number: _____

Is it okay to leave voicemails containing medical information on this phone (circle)? Yes No

Is this contact authorized to receive/pick up medical records (circle)? Yes No

Contact Name: _____ Relationship: _____

Contact Phone Number: _____

Is it okay to leave voicemails containing medical information on this phone (circle)? Yes No

Is this contact authorized to receive/pick up medical records (circle)? Yes No

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*By signing this document, I am acknowledging that only those authorized by me will be able receive my medical information. Any changes must be provided in writing to the office.*

Patient Signature: _____ Date: _____

*If you are NOT the patient, please specify relationship to patient: _____

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## About You

Patient Name: _____ DOB: _____

What brings you in today? _____

_____

**Medical History:**

Have you ever had any of the following (circle)?

| | | | | | |
|---|---|---|---|---|---|
| Diabetes ..... | yes | no | Bleeding tendency..... | yes | no |
| Hypertension..... | yes | no | Acute infections..... | yes | no |
| Cancer..... | yes | no | Sexually Transmitted Diseases | yes | no |
| Stroke..... | yes | no | Hereditary defects..... | yes | no |
| Heart trouble..... | yes | no | Arthritis/gout..... | yes | no |
| Convulsions..... | yes | no | | | |

Please list any medical conditions you've had or currently have: _____

_____

_____

☐ **Please check here if you do not have any medical conditions you are aware of**

| Please list any hospitalizations, surgeries, or serious injuries: | When did this occur (month/year)? |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

☐ **Please check here if you have never been hospitalized, or had any surgery or serious injury**

Do you have any allergies to drugs, foods, or medications (circle)? Yes No

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

**Social History:**

Have you consumed alcohol at all the past year (circle)? Yes No

**If yes**, how often (circle)? Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

Typically, how many drinks did you consume while drinking (circle)? 1-2 3-4 5-6 7-9 10 or more

How often did you have 6 or more drinks on one occasion the past year (circle below)?

Never Less than monthly Monthly Weekly Daily or almost daily

What is your tobacco use status (circle)? Current user Former user Never smoked

**If a former user**, how long has it been since you quit? _____ How long did you smoke? _____

How many cigarettes, on average, did you typically smoke per day? _____

**If a current user**, how long have you smoked for? _____ Are you thinking about quitting? ____

How many cigarettes, on average, do you smoke per day? _____

Have you used drugs, other than for medical reasons, in the past 12 months (circle)? Yes No

**If yes**, are you still currently using (circle)? Yes No

Drug(s) of choice: _____

Do you have exposure to any of the following at work or home (circle below)?

Fumes Dust Solvents Noise Chemicals Smoke Animal hair

**Medications/Pharmacy:**

Are you currently taking any medication regularly (circle)? Yes No

**If yes**, do you have an up-to-date list of your medication to provide (circle)? Yes No

Please provide the office with your **primary pharmacy** choice below, if you usually use mail order pharmacy, please provide pharmacy you would fill an immediate prescription at (i.e. antibiotic):

***even if you do not regularly use a pharmacy, please provide a pharmacy you would use if the doctor were to write you a prescription, such as one close to home***

Pharmacy Name: _____ Pharmacy Phone Number: _____

Address (provide approximate location if address unknown): _____

City: _____

If you usually use a mail order pharmacy for your medications, please provide information below:

Pharmacy Name: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Address: _____ City: _____ State/Zip: _____

**Family History:**

Please provide as much information as possible about any family history of any medical conditions you're aware of (i.e. hypertension, diabetes, heart attack, cancer, stroke, etc.)

| Relative | Age | Sex | Medical Conditions | If deceased, cause of death |
|---|---|---|---|---|
| Father | | M | | |
| Mother | | F | | |
| Siblings | | | | |
| | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| | | | | |
| | | | | |

☐ **Please check here if you do not have any family medical history that you are aware of**

**Preventative Care/Wellness:**

Are you 50 years old or older (circle)? Yes No

**If yes**, have you had a colonoscopy within the past 10 years (circle)? Yes No

If yes, how long ago did you have it done? _____ Where at? _____

**If yes**, have you received a pneumonia vaccine within the past 5 years (circle)? Yes No

If yes, how long ago did you have it done? _____ Where at? _____

Are you a woman 21 years of age or older (circle)? Yes No

**If yes**, have you had a pap smear performed within the past 2 years (circle)? Yes No

If yes, how long ago did you have it done? _____ Where at? _____

Are you a woman 50 years of age or older (circle)? Yes No

**If yes**, have you had a mammogram performed within the past year (circle)? Yes No

If yes, how long ago did you have it done? _____ Where at? _____

Lately, have you had little interest or pleasure in doing things (circle)? Yes No

Lately, have you felt down, depressed, or hopeless (circle)? Yes No

Did you receive a flu shot for the most recent flu season (circle)? Yes No

**If yes**, when did you last receive it? _____ Where at? _____