Covenant Medical Group

2501 Compass Road • Suite 100 • Glenview, IL 60026
Telephone: (847) 901-5200 • Facsimile: (847) 901-5225

Michael Caughron, M.D. • CHRISTOPHER HO DO KATHERINE LEWINSKI DO
Claudia Petersen, M.D. • Gregory Wallman D.O. • Frank Weschler, M.D.

Patient Information

Name:	Last	First		Middle Initial	
Birthdate:	Month Day Year	Sex: F M			
Status: Single Married Separated Divorced Widow(ed)		Spouse name:			
Address:	Street			Apt	
	City		State	ZIP	
Phone:	Home	Work	Mobile		
Primary Physician:	CAUGHRON PETERSEN WALLMAN WESCHLER LEWINSKI HC				

Emergency Contact Information

Contact Name:	Last	First	
Relation to patient:		Phone:	

Employment Information

Occupation:			
Employer:		Phone:	
Address:	Street City	State	ZIP

Consent for Release of Medical Information

Federal law limits disclosure of medical information without written consent of the patient. Please indicate how your medical information may be disclosed in the event you are not able to be reached directly:

Covenant Medical Group may leave a message on my answering machine or voice mail at: Home Work Mobile		
Covenant Medical Group may leave a message with the following person(s):		
Name	Phone	Relation
Name	Phone	Relation
Name	Phone	Relation

I hereby testify that the information I have provided is true to the best of my knowledge.

I understand that I may request a copy of the Notice of Privacy Practices form which provides detailed information about how Covenant Medical Group may use and disclose my confidential information and that Covenant Medical Group reserves the right to change privacy practices. I agree that this serves as the Receipt of Notice of Privacy Practices.

I understand that I am responsible for providing current insurance information at each visit. I authorize Covenant Medical Group to release to my insurance company information acquired in the course of my examination and treatment and I authorize benefits to be paid to the doctors of Covenant Medical Group directly. I understand that I am responsible for any unpaid balance.

Signature:	Date:

(If patient is a minor, signature of parent or legal guardian)

Covenant
Medical
Group

2501 Compass Road, Suite 100, Glenview, IL 60026-8000 tel: 847-901-5200 internet: covmedgrp.com
*Michael Caughron, MD * C Ho, HO * Katherine Lewinski, DO * Claudia Petersen, MD * Gregory Wallman, DO * Frank Weschler, MD*

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, and/or HEALTHCARE OPERATIONS

Patient: _____

Last *First* *MI* *DOB*

Address: _____

Street Address *City* *State* *Zip*

I understand that as part of my healthcare, ***Covenant Medical Group, LLC*** originates and maintains my health records of health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as a:

- basis for planning my care and treatment;
- means of communication among the healthcare professionals who contribute to my care;
- source of information for applying my diagnosis treatment information to my bill;
- means by which a third-party payer can verify that services billed were actually provided; and
- tool for routine healthcare operations such as assessing quality of care and reviewing the competence of healthcare professionals

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation; and
- To revoke this consent in writing, except for the extent that the organization has already taken action in reliance thereon. I request the following restrictions to the use of disclosure of my health information:

_____

_____

I understand that I may request a copy of the Notice of Privacy Practices form which provides detailed information about how ***Covenant Medical Group, LLC*** may use and disclose my confidential information and that ***Covenant Medical Group, LLC*** reserves the right to change privacy practices, I agree that this serves as the Receipt of Notice of Privacy Practices.

I understand that I am responsible for providing current insurance information at each visit. I authorize ***Covenant Medical Group, LLC*** to release to my insurance company information acquired in the course of my examination and treatment and I authorize benefits to be paid to the doctors of ***Covenant Medical Group, LLC*** directly. I understand that I am responsible for any unpaid balance.

_____

Patient: Print Name Signature Date

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FAX#: *Michael Caughron, MD (847-904-4913) * * Katherine Lewinski, DO (847-904-4905)*
*Claudia Petersen, MD (847-904-4906) * Gregory Wallman, DO (847-904-4907) * Frank Weschler, MD (847-904-4908)*
Christopher Ho DO(847-904-7118)

Patient Portal Web Based Access

Website: www.covmedgrp.com

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Phone: H_____ C: _____ W:_____

Email Address: _____
(unique email - husband/wife can't share the same email)

Physician Name:_____

Consent to: Voice Message: ___Yes ___ No Text Message: ___Yes ___No

For assistance, please contact 847-901-5200 or 847-901-5236 or 847-901-5251.

Name _____ SS# _____ Date _____
Address _____ Occupation _____
Phone (home) _____ (work) _____ Date of birth _____ Age _____
Chief complaint _____

DRUG ALLERGIES

_____
_____
_____
_____
_____

CURRENT MEDS

_____
_____
_____
_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

❑ Headache _____
❑ Shortness of breath _____
❑ Heart palpitations _____
❑ Heart murmur _____
❑ Chest pain _____
❑ Dizziness/Fainting _____
❑ Peripheral vascular disease _____
❑ Allergies/Hay fever _____
❑ Asthma _____
❑ Bronchitis _____
❑ Pneumonia _____
❑ Ulcer _____
❑ GI disorder _____
❑ Lactose intolerance _____
❑ Gallbladder disease _____
❑ Prostate Problems _____
❑ Bowel irregularity _____
❑ Incontinence _____
❑ Overactive bladder _____
❑ Frequent Urination _____
❑ Sexual/menstrual dysfunction _____
❑ Venereal disease _____
❑ Frequent infections _____
❑ Hepatitis _____
❑ Anemia _____
❑ Arthritis _____
❑ Osteoporosis _____
❑ Nervousness _____
❑ Depression _____
❑ Gout _____
❑ Scarlet fever _____
❑ Chronic rashes _____
❑ Rheumatic fever _____
❑ Mumps _____
❑ Measles _____
❑ Rubella _____
❑ Polio _____
❑ Diphtheria _____
❑ Tetanus _____

Do you have frequent, sudden urges to urinate?

❑ Yes ❑ No

How often do you urinate during the day?

_____ times

How often do you wake up at night to urinate?

_____ times

Do you experience wetting or leaking accidents?

❑ Yes ❑ No

MEN ONLY: It's common for men to occasionally experience erection problems. Is this something that happens to you?

❑ Yes ❑ No

How often does this occur?

❑ Frequently ❑ Sometimes ❑ Rarely

Name _____

History & Physical

Name _____ SS# _____ Date _____

Habits

- ❑ Smoke: Packs daily _____ How long? _____ Interested in stopping? _____
- ❑ Exercise routine: _____
- ❑ Coffee: Cups daily _____ Other caffeine _____
- ❑ Alcohol: Type _____ Amount _____
- ❑ Diet: Salt intake _____ Fat intake _____
- ❑ Sleep: Difficulty falling asleep _____ Continuity disturbances _____ Snoring _____ Early morning awakening _____ Daytime drowsiness _____ Other _____

Review of Systems

❑ Neurologic _____ ❑ GI _____ ❑ Cardiovascular _____
❑ GU _____ ❑ Cerebrovascular _____ ❑ Musculoskeletal _____
❑ Peripheral vascular _____ ❑ Dermatologic _____ ❑ Hematologic _____

Physical Exam

Temperature _____ Pulse _____ BP _____
Height _____ Weight _____ Respiration _____
General Appearance _____

	N	AB	Notes
Skin			
HEENT			
Neck			
Thyroid			
Lymph nodes			
Veins/carotid			
Chest			
Lungs			
Heart			
Abdomen			
Genital			
Rectal			
Extremities			
Joints			
Clubbing/cyanosis			
Peripheral pulses			
Edema			
Neurologic			

Tests Ordered

- ❑ Chest X-ray _____ ❑ Barium enema _____ ❑ TB test _____ ❑ Flexsigmoidoscopy _____
- ❑ Kidney X-ray _____ ❑ Gallbladder _____ ❑ Air contrast: Obstruction series _____ ❑ ERCP _____
- ❑ UGI series _____ ❑ Electrocardiogram _____ ❑ Endoscopy _____ ❑ Liver biopsy _____
- ❑ Colonoscopy _____ ❑ Blood tests _____ ❑ ELISA _____ ❑ Elevated ALT _____

Name _____