1950 45th St. Suite 205
Munster, IN 46321

Arthur H. Katz MD., S.C

2601 W. Lincoln Hwy Suite 112
Olympia Fields, IL 60461

PATIENT INTAKE FORM

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

PATIENT INFORMATION *(PLEASE PRINT)*

First Name: _____ Last Name: _____ Date of Birth: _____

Sex: _____ Marital Status: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Name: _____ Relationship: _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

REFERRALS

Primary Care Physician: _____ Phone ( ) _____ Address: _____

Referring Provider: _____ Phone ( ) _____ Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insurance Plan: _____

Policy Holder: _____ Date of Birth: _____

Secondary Insurance: _____ Insurance Plan: _____

Policy Holder: _____ Date of Birth: _____

MEDICAL HISTORY

(Please Circle)

Alcohol Use	YES	NO	High Blood Pressure	YES	NO
Allergies/Hay Fever	YES	NO	HIV Positive or AIDS	YES	NO
Arthritis	YES	NO	Kidney Disease	YES	NO
Asthma	YES	NO	Liver Disease	YES	NO
Cancer	YES	NO	Lung Disease	YES	NO
Diabetes	YES	NO	Meningitis	YES	NO
Drug Use	YES	NO	Multiple Sclerosis	YES	NO
Elevated Cholesterol	YES	NO	Osteoporosis	YES	NO
Fainting/Dizzy Spells	YES	NO	Psychiatric Treatment	YES	NO
GERD	YES	NO	Sinus Disease	YES	NO
Glaucoma	YES	NO	Smoker	YES	NO
Headaches	YES	NO	Stroke	YES	NO
Heart Problems	YES	NO	Thyroid Disease	YES	NO
Hepatitis (Jaundice)	YES	NO	Ulcer (Stomach)	YES	NO

Do you snore or have sleep apnea? YES NO

Have you had a sleep study done? YES NO

- If yes, where? _____ When? _____

Did you have your tonsils or adenoids removed? YES NO

- If yes, where? _____ When? _____

Do you have difficulty breathing through your nose? YES NO

Do you often have heartburn, acid reflux or been diagnosed with GERD? YES NO

Please list any previous surgeries or hospitalizations from the last ten years: _____

_____

Skin Diseases

Do you currently have any moles or lesions? YES NO

Have you ever had a mole/lesion removed? YES NO

- If yes, how many? _____ Location: _____

Primary Care Physician: _____ Phone: _____

Pharmacy & Town: _____ Phone: _____

Patient Signature: _____ Date: _____

MEDICATION INFORMATION

Current Medications: Include all prescription, over-the-counter medications, vitamins & diet aids.

Name	Dosage	Name	Dosage

Please list any food or medication allergies: _____

_____

Please circle Yes or No for any of the following medications you have tried

Pill	**Did it Help?**	**Inhaler?**	**Did it Help?**
Allegra	YES NO	Advair	YES NO
Allegra D	YES NO	Albuterol	YES NO
Clarinex	YES NO	Asmanex	YES NO
Claritin	YES NO	Azmacort	YES NO
Claritin D	YES NO	Flovent	YES NO
Singulair (Montelukast)	YES NO	Foradil	YES NO
Zyrtec	YES NO	Proventil	YES NO
Zyrtec D	YES NO	Pulmicort	YES NO
		Serevent	YES NO
		Singular	YES NO
Nasal Spray	**Did it Help?**	Xopenex	YES NO
Astelin (Azelastine)	YES NO	Spiriva	YES NO
Flonase (Fluticasone)	YES NO	Combivent	YES NO
Nasonex	YES NO		
QNasl	YES NO		
Atrovent (Ipratropium Bromide)	YES NO		

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt and/or Review of Privacy Practices

In an effort to communicate with you more effectively and keep your Protected Health Information confidential, we are asking that you complete the following form. This form lets you decide who we can release your information to and for what reason. If you have any questions about this form, please ask.

I, _____ have either received a paper copy or reviewed the office copy of Dr. Arthur H. Katz MD., S.C Notice of Privacy Practices.

Dr. Katz or his staff may discuss or leave information about my Protected Health information and/or financial matters to the people listed below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

In addition to the above, how may we communicate to you regarding any health issues or concerns which may be confidential (For example: lab results, x-rays, appointment reminders, etc) PLEASE ANSWER EVERY QUESTIONS BELOW.

Mailed (sealed privacy mail only) YES NO

Can we leave a message on an answering machine? YES NO

Can you be contacted at work? YES NO

- If so, please provide a phone number: _____ Ext. _____

Can you be contacted on your mobile phone? YES NO

- If so, please provide a phone number: _____ Ext. _____

Other: _____

Patient/Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____