LINCOLN PARK HEART CENTER
PERSONALIZED PREVENTIVE CARDIAC CARE

2266 North Lincoln Avenue, 3rd Floor, Chicago, Illinois 60614
773•327•8008 773•423•0289 lphc.chicago@gmail.com
www.LincolnParkHeartCenter.com

## PATIENT INFORMATION

| NAME *(Last, First Middle)* | | | DATE |
|---|---|---|---|
| | | | |
| ADDRESS *(City, State, Zip Code)* | | | |
| | | | |
| HOME PHONE | DAY/CELL PHONE | | PERSONAL E-MAIL |
| | | | |
| GENDER:M/F | MARITAL STATUS | SS# | DATE OF BIRTH *(Month, Date, Year)* |
| | | | |
| OCCUPATION | | | |
| | | | |
| EMERGENCY CONTACT | RELATIONSHIP | | PHONE |
| | | | |

## INSURANCE INFORMATION *(Please provide INSURANCE CARD to our staff)*

| PRIMARY CARD HOLDERS NAME *(Last, First Middle)* | YOUR RELATIONSHIP TO PRIMARY CARD HOLDER |
|---|---|
| | |
| INSURED DATE OF BIRTH *(Month, Date, Year)* | INSURED SS# |
| | |

## AUTHORIZATION

I authorize release of information to my insurance career for this claim and request that payment of benefits be made payable to: Dr. Sukhjit S. Gill M.D. and Dr. Sanjay S. Gill M.D.

Signature of Patient or Legal Guardian: .....

## MEDICAL HISTORY

REFERRED BY DOCTOR

REASON FOR VISIT/SYMPTOMS

| | | |
|---|---|---|
| HAVE YOU EVER HAD HEART TROUBLE IN THE PAST: | NO: ..... | YES: ..... |
| DO YOU SMOKE CIGARETTES: | NO: ..... | YES: ..... |
| DOES ANYONE IN YOUR FAMILY HAVE HEART TROUBLE: | NO: ..... | YES: ..... |
| HAVE YOU BEEN RECENTLY ADMITTED TO A HOSPITAL: | NO: ..... | YES: ..... |
| DO YOU HAVE ANY ALLERGIES: | NO: ..... | YES: ..... |

PLEASE LIST ALL MEDICATIONS AND OVER THE COUNTER SUPPLEMENTS THAT YOU TAKE:

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

SIGNATURE OF PATIENT/GUARDIAN

DATE