XIAOHUA FENG, MD

PATIENT REGISTRATION

Name: ____ ________________________ _________
Last First M.I.

Address: ____

____

____

Telephone:

_______________________ _______________________ _________________________
Cell Home Work

Social Security #: ____________________________ Male: _____ Female: _____ Other: ______

Birth Date: _________________________________ Age: ______

E-mail address: ____

Occupation: ____

Place of Employment: ____

Members of your household: *(Names and Ages)*

__________________________________ ____________________________________

__________________________________ ____________________________________

__________________________________ ____________________________________

__________________________________ ____________________________________

Who referred you to (or how did you hear about) me? _____________________________________

May I contact this person to acknowledge the referral? *(Please circle one)* Yes / No

Many insurance companies require that I submit clinical information in order to obtain pre-certification for treatment; otherwise they may refuse to cover the treatment. Do I have your permission to submit medical or other information necessary to process such a claim? *(Please circle one)* Yes / No

____ _________________________________
Signature Date

625 N MICHIGAN AVE | SUITE 1910 | CHICAGO, IL 60611
737 N MICHIGAN AVE | SUITE 1200 | CHICAGO, IL 60611
SFENGMD@GMAIL.COM | T: 312-588-6200 | F: 832-621-0428

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PATIENT MEDICAL / MEDICATION HISTORY

Patient Name: ____

Primary Physician (PCP):
Name ____________________________________ Phone _________________________

Other Physicians / Other Providers / Treatments:
Name ____________________________________ Phone _________________________
Nature of Treatment: ____

Name ____________________________________ Phone _________________________
Nature of Treatment: ____

Name ____________________________________ Phone _________________________
Nature of Treatment: ____

PSYCHIATRIC MEDICATIONS

Name of medication	Please Circle	Dose / Response / Side Effects
	Current/Prior	
	Current/Prior	
	Current/Prior	
	Current/Prior	
	Current/Prior	
	Current/Prior	
	Current/Prior	

OTHER/NON-PSYCHIATRIC MEDICATIONS

Name of Medication	Dose	Purpose / Response /side effects

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Do you have any allergies to medications? *(Please circle)* No / Yes *(Please explain reactions below)*
Please list any relevant prior/current medical problems, medication allergies, or additional information:

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME: ____

I hereby authorize and give my full consent that XIAOHUA FENG, MD contact and obtain and/or provide my medical history and other related information from/to the following people/organizations:

NAME:	TELEPHONE:
____	____
____	____
____	____

I understand that this correspondence may involve a conversation or a transfer or written material and that I have the right to revoke the above authorization at any time.

SIGNATURE: ___________________________________

PRINTED NAME: ________________________________

DATE: ____

NOTICE OF CONFIDENTIALITY

It is understood and agreed to by the recipient of the documents or communication requested above that this is privileged and protected health information and is confidential material, by law. Further disclosure or release of the documents or their contents by the recipient or any other party is not authorized without your written consent.

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