GOLF-WESTERN SURGICAL SPECIALISTS
JOUBIN KHORSAND, M.D.

MEDICAL HISTORY FORM

PATIENT INFORMATION **Today's Date** _____

_____
Name (Last) (First) (Middle)

_____
Address City State Zip

Home Phone: (____)_____ Cell Phone: (____)_____

Work Phone: (____)_____ Email Address:_____

Height: _____ Weight: _____ Age: ____ Date of Birth: _____ Sex: M / F
SS#:_____ Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Employer Information
Employed? ☐ yes ☐ no ☐ retired ☐ disabled ☐ student Workers comp? ☐ yes ☐ no

_____ _____
Employer Name Occupation

_____
Address

Emergency Contact
Name:_____ Phone: (____)_____
Relationship _____

Insurance name:_____ Policyholder Name:_____
Date of Birth : _____ Relationship:_____

REFERRING PHYSICIAN
Name: _____
Phone: _____

PRIMARY CARE PHYSICIAN
Name: _____
Phone: _____

PREFERRED PHARMACY
Pharmacy: _____ Phone: (____)_____
Address: _____ City/Zip _____

HISTORY OF PRESENT ILLNESS
Reason for today's visit: _____
_____

LATEX ALLERGY: Yes/No **High Blood Pressure: Yes/No** **Diabetes: Yes/No**
Cardiac History: Yes/No **Cancer History: Yes/No**

ALLERGIES: Type of allergy (medications, food, metals, etc.) and **reaction**:
_____
_____

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Patient Name: _____

REVIEW of SYSTEMS:
Have you ever experienced or do you currently have any of the following signs or symptoms? If "yes", please describe:

SYMPTOMS	**Circle**	**Describe all 'Yes' responses**
Eyes (blurred vision, double vision, loss of vision)----------	YES / NO	_____
Cardiovascular (chest pain, palpitations, ankle swelling)-----	YES / NO	_____
Respiratory (shortness of breath, cough, snore)----------	YES / NO	_____
Gastrointestinal (ulcer, gastritis, GI bleed, jaundice)----------	YES / NO	_____
Genitourinary (burning, bleeding, difficulty urinating)--------	YES / NO	_____
Musculoskeletal (joint, muscle, back or neck pain)----------YES	/ NO	_____
Skin (delayed healing, rash, acne, cellulites, psoriasis)--------	YES / NO	_____
Neurological (numbness, tingling, weakness)----------	YES / NO	_____
Endocrine (weight gain/loss, excess thirst/urination)----------YES	/ NO	_____
Hematologic (bruising, bleeding, clotting disorder)----------	YES / NO	_____
Allergic/Immunologic (rash, swelling, wheezing)----------YES	/ NO	_____

PAST MEDICAL and FAMILY HISTORY:

DISEASE / CONDITION **Please Circle**	CIRCLE	**DESCRIBE IN DETAIL**
High Blood Pressure ----------	Self / Family	_____
Diabetes Mellitus ----------	Self / Family	_____
High Cholesterol ----------	Self / Family	_____
Angina / MI / Cardiomyopathy ----------	Self / Family	_____
MVP / Rhythm Problem----------	Self / Family	_____
Stroke / TIA / Seizures----------	Self / Family	_____
Asthma / COPD / Emphysema----------	Self / Family	_____
GERD / Ulcers / Colitis----------	Self / Family	_____
Hepatitis / Liver / Gallbladder----------	Self / Family	_____
Kidney / Failure / Stones----------	Self / Family	_____
UTI / BPH----------	Self / Family	_____
Skin Cancer----------	Self / Family	_____
Other Cancer----------	Self / Family	_____
Bleeding / Clotting Disorder----------	Self / Family	_____
Thyroid / Endocrine Problem----------	Self / Family	_____
HIV / AIDS / TB----------	Self / Family	_____

Other_____

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Patient Name: _____

PAST SURGICAL HISTORY:
Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____

SURGICAL COMPLICATIONS: _____

_____

SLEEP APNEA: Do you have Sleep Apnea? ☐ yes ☐ no

MEDICATIONS (Prescription / Nonprescription / Herbal supplements / Vitamins):
Medication _____

_____

_____

_____

_____

_____

SOCIAL HISTORY:
Race: Caucasian / Hispanic / African American / Asian / Native Hawaiian / Native Indian / Other / Refused
Ethnicity: Hispanic / Non-Hispanic / Refused to report
Language: English / Spanish / Other _____

Do you live alone: ☐ yes ☐ no If no, who do you live with? _____

Tobacco use: ☐ yes ☐ no Packs per day: _____ Pipe? ☐ yes ☐ no
Smokeless Tobacco? ☐ yes ☐ no ☐ Quit Years Smoked _____

Alcohol Use: ☐ never ☐ occasional ☐ daily ☐ heavy History of alcoholism? ☐ yes ☐ no
History of drug use: ☐ yes ☐ no

Women Only:
Are you pregnant: ☐ yes ☐ no Breastfeeding? ☐ yes ☐ no Date of last menstrual period:____
Birth Control: ☐ yes ☐ no How Long? _____ Hormones? ☐ yes ☐ no How Long? _____
Number of Pregnancies: _____

Patient/Guardian Statement:
To the best of my knowledge, the above information is accurate and complete.

_____ _____
Patient signature Date Guardian signature Date

_____
Guardian Printed Name

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Acknowledgement of Receipt of Golf-Western Surgical Specialist Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your care provider. We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at Golf-Western Surgical Specialists.

The patient, or legal guardian is always responsible for payment. In consideration of services to be rendered, you as the undersigned patient of guarantor for patient, agree to pay Golf-Western Surgical Specialist for all services provided to you (or the patient, as applicable) at the established rates, including deductibles, co-payments or other charges, as permitted by third party payors. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by Golf-Western Surgical Specialist in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.

Additionally:

- Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) has NOT been provided.
- All patients must complete our "patient registration form" and other forms provided at the time of registration.
- For cases in which we bill the insurance directly, we MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD.
- Please notify us immediately of any changes in your insurance information or coverage.
- You are ultimately responsible for payment of all services.

Medicare : We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible and charges for any service not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance has paid.

HMO/PPO: ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. As the owner of your policy, you are responsible for verifying that we are an in-network provider under your plan. If you are an HMO member, you will not be billed as long as you have obtained the necessary referrals.

Insurance Disputes: If there is a dispute regarding the payment of your insurance or certain workers' compensation claim, Golf-Western Surgical Specialist has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

I understand that the office agrees to bill insurance carrier as a courtesy to me. I must submit information as needed by my insurance company to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

_____ _____
Signature of Patient Date

_____ _____
Signature or Authorized Representative Date

_____ _____
Print Name of Authorized Representative Relationship

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____ **Date of Birth:** _____

The notice of Privacy Practice (NPP) tells you how we use and share your health records. It also describes your rights with respect to your health records. **Please read it.**

- We will use and share your health records to treat you and to bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

Signature of Patient _____

Signature if Authorized Representative _____ Date: _____

Name of Authorized Representative _____ Relationship _____

PHONE MESSAGE AND CONTACT AUTHORIZATION

Please CHECK the appropriate answer below:

Do the physician and staff of Golf-Western Surgical Specialists have your permission to leave messages containing medical and/or financial information on your **answering machine?**

☐ **At home** ☐ **Yes** ☐ **No**
☐ **At work** ☐ **Yes** ☐ **No**

Please complete below: **I give authorization to the doctor and staff of Golf-Western Surgical Specialists to discuss my medical and /or financial information with the following people:**

	Name	Relationship	Phone
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____

I understand that it is my responsibility to inform Golf-Western Surgical Specialists or any desired changes in this authorization.

Patient initials: _____

GOLF-WESTERN SURGICAL SPECIALISTS
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HEALTH CARE CONSENT

Patient Name: _____ **Date of Birth:** _____

MR#: _____
(Office use only)

CONSENT TO EVALUATE/TREAT: I, for myself (or the patient named above), hereby consent to such medical evaluation and/or treatment and diagnostic procedures (e.g. ex-rays, MRI, videotaping) as necessary and appropriate for my condition or illness based on the judgment of my physicians(s), physician assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

PERSONAL BELONGINGS: I assume full responsibility for all items of personal property that I have brought to Golf-Western Surgical Specialist and release Golf-Western Surgical Specialist of all liability in the event of loss or damage to such property.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____

Relationship of Authorized Representative: _____

Advocate
Lutheran General Hospital

Advocate Lutheran General Hospital news

2013

1st Surgeon to Reach 100 Single Site Robotic Surgeries in Illinois

On January 10, 2013, Dr. Joubin Khorsand became the first surgeon in Illinois and one of the first in the country to complete 100 single-site robotic cholecystectomies-an operation used for gallbladder removal through a two centimeter incision through the belly button. When Dr. Khorsand began performing single-site robotic surgery in June 2012, he was the first physician in the Northern Suburbs to perform this surgery. Since then, he has seen the incredible benefits of this virtually scarless surgery.

"The advantage of robotic surgery especially single site robotic cholecystectomy using the DaVinci Robotic Surgery System include: better visualization because of 3 dimensional view as a result it makes the operation safer," said Dr. Joubin Khorsand. "There is also less pain, less bleeding, a shorter hospital stay and higher patient satisfaction."

In addition to single-site, Advocate Lutheran General Hospital offers the most comprehensive robotic surgery program in the Northern suburbs of Chicago. This includes robotic surgery for the treatment of a variety of cancers including: colorectal, endometrial, esophageal, lung, pancreatic, gynecologic and throat as well robotic hysterectomy, robotic myomectomy and numerous other procedures. For more information on these and other robotic procedures available at Lutheran General visit www.advocatehealth.com/luth/robotics.

Golf-Western Surgical Specialists, LTD.
General Surgery & Surgical Oncology
8901 Golf Road, Suite 305
Des Plaines, Illinois 60016
(847) 299-8844
FAX (847) 299-6420
joubinkhorsandmd.com

J. Khorsand, MD., F.A.C.S.
Diplomate American Board Of Surgery

Welcome to Golf-Western Surgical Specialists. In order to make your appointment run as smoothly as possible we ask that you fully complete both sides of all the pages of the enclosed patient information form and bring the form with you on the day of your scheduled consultation appointment. Also please make sure you bring your insurance card and photo ID. **If your insurance requires a copay we only accept cash or check.**

Attn: Medicaid – Allkids Insurance. The copay has recently been raised to $3.65. Please bring exact change.

If a surgical consultation, please bring your calendar with available dates to schedule your procedure.

We will be starting electronic medical records so please be patient with us while we learn the new system. There may be some delays but we will do our best to be on time.

Our office is located at 8901 Golf Rd. Suite 305. **Elevators are located in the rear of the building, so please park in the back parking lot.** Directions can be found on our web page: joubinkhorsandmd.com.

We look forward to seeing you.

Sincerely,

Golf-Western Surgical Specialists