SOUTHERN INDIANA COMMUNITY HEALTH CARE
PO BOX 270, 420 W. LONGEST ST * PAOLI, IN 47454
PHONE (812) 723-3944 * FAX (812) 723-5292

Patient: ____

Last Name | First Name | Middle Initial | Social Security #

Mailing Address ____

City: ____________ State: ________ Zip ________ Language: ☐ English ☐ Spanish ☐ Other

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Email: ____________ Sex: ☐ Male ☐ Female Age: ________ DOB: ____________
(Access Health Record 24hrs a Day, 7 Days a Week)

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Race: ☐ White ☐ Black/African American (no Hispanic or Latino) ☐ Hispanic or Latino (all races)
☐ Mix ☐ Asian ☐ Native Hawaiian ☐ Other: ____________

Patient Employed By: ____________ Occupation: ____________

Billing Address ____________ Phone Number ____________

☐ Spouse ☐ Parent Guarantor Name: ____________ Birthday: ____________ SSN: ____________

Address if different from patient: ____________ City: ____________ State: ________ Zip ________

Business Name: ____________ Phone Number: ____________

Do you have Medical Insurance? ☐ Yes ☐ No Insurance Company: ____________

Person Insured: ____________ ID #: ____________ Group #: ____________ SSN: ____________

Birthdate: ____________

Secondary Insurance? ☐ Yes ☐ No Insurance Company: ____________

Person Insured: ____________ ID #: ____________

Group #: ____________ SSN: ____________ Birthdate: ____________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

____

Name | Relationship | Phone Number

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____________ and assign directly to SICHC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission.

____

Signature of Insured/Guardian | Date

MEDICARE AUTHORIZATION

I request that payment of authorized benefits be made either to me or on my behalf to DICHC for any services furnished to me by my physician/nurse practitioner. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to the related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician/nurse practitioner agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____

Beneficiary Signature | Date

Patient Name: ____DOB:__________

Past medical History: Please Check Box

- ☐ Alcohol/Drug Use
- ☐ Bleeding/Clotting Tendencies
- ☐ Cancer
- ☐Chronic Pain
- ☐ Congenital Defects
- ☐ COPD/Asthma
- ☐ Diabetes
- ☐ Depression
- ☐ Gastric Reflux
- ☐ Genital/Urologic Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mononucleosis
- ☐Neurologic Disease
- ☐ Renal/kidney Disease
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sleeping Disorder
- ☐ Smoking History
- ☐ Stomach Ulcers
- ☐ Smoking History
- ☐ Tuberculosis

<u>Medications: *Please include all medications, including over the counter and supplements.</u>

IF YOU NEED MORE ROOM PLEASE USE THE BACK OF THIS PAPER. ***

Name: ________________________ Dose: _________ Frequency: _______________
Name: ________________________ Dose: _________ Frequency: _______________
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Name: ________________________ Dose: _________ Frequency: _______________
Name: ________________________ Dose: _________ Frequency: _______________
Name: ________________________ Dose: _________ Frequency: _______________
Name: ________________________ Dose: _________ Frequency: _______________

Hospital/Surgical History:

Explain: ____
Date: _______________Facility: _____________________________________
Explain: ____
Date: _______________Facility: _____________________________________
Explain: ____
Date: _______________Facility: _____________________________________
Explain: ____
Date: _______________Facility: _____________________________________

Patient Name: ____ DOB: __________

Allergies:

1) Medications: __________________ Reaction: _________________________
2) Medications: __________________ Reaction: _________________________
3) Medications: __________________ Reaction: _________________________
4) Environmental: ____
5) Food: ____

Social History:

☐ Married ☐ Single ☐ Divorced ☐ Widow (please check box)

Occupations: ____________________________ Education: ______________

Habits:

Do you exercise?	☐ Yes	☐ No	Type/Frequency: ______________________				
Do you smoke?	☐ Yes	☐ No	How Much: ____________	Quit?	☐ Yes	☐ No	Date: ______
Alcohol Use?	☐ Yes	☐ No	How Much/Often: ________	Quit?	☐ Yes	☐ No	Date: ______
Drugs Use?	☐ Yes	☐ No	Type/Frequency: ________	Quit?	☐ Yes	☐ No	Date: ______
Caffeine Use?	☐ Yes	☐ No	Cups per day: ______________				

Date of last Immunization?

Influenza: Date: ____________________
Pneumovax: Date: ____________________
Tetanus: Date: ____________________
Zostavax (Shingles): Date: ____________________

Have you traveled to other countries within the last year? ☐ Yes ☐ No

Where: ____________________________ Date: ____________________
Where: ____________________________ Date: ____________________
Where: ____________________________ Date: ____________________

Females Only:

When was you last menstrual period? ____________________________
Number of Pregnancies? ____________________________
Number of Births?: ____________________________

Patient Name: ____ DOB: __________

Do you have Advanced Directives?

Living Will: ☐ Yes ☐ No

Durable Power of Attorney: ☐ Yes ☐ No

Family History: Please check box and circle relationship to you

PFG: Paternal Grandfather PGM: Paternal Grandmother M: Mother F: Father
MGF: Maternal Grandfather MGM: Maternal Grandmother B: Brother S: Sister

Arthritis	☐	PGF	PGM	MGF	MGM	M	F	B	S
Asthma	☐	PGF	PGM	MGF	MGM	M	F	B	S
Cancer (type) ____________	☐	PGF	PGM	MGF	MGM	M	F	B	S
COPD	☐	PGF	PGM	MGF	MGM	M	F	B	S
Coronary Artery Disease	☐	PGF	PGM	MGF	MGM	M	F	B	S
Depression/Anxiety	☐	PGF	PGM	MGF	MGM	M	F	B	S
Diabetes	☐	PGF	PGM	MGF	MGM	M	F	B	S
Gastric Reflux	☐	PGF	PGM	MGF	MGM	M	F	B	S
Heart Attack	☐	PGF	PGM	MGF	MGM	M	F	B	S
High Cholesterol	☐	PGF	PGM	MGF	MGM	M	F	B	S
Hypertension/High Blood Pressure	☐	PGF	PGM	MGF	MGM	M	F	B	S
Migraines	☐	PGF	PGM	MGF	MGM	M	F	B	S
Obesity	☐	PGF	PGM	MGF	MGM	M	F	B	S
Stomach Ulcers	☐	PGF	PGM	MGF	MGM	M	F	B	S
Stroke	☐	PGF	PGM	MGF	MGM	M	F	B	S
Other: ____________	☐	PGF	PGM	MGF	MGM	M	F	B	S

Other Healthcare Providers (Complete if Appropriate)

Dentist: ______________________ Location: ______________ Last visit: ________

Eye Doctor: ______________________ Location: ______________ Last visit: ________

Gynecologist: ______________________ Location: ______________ Last visit: ________

Urologist: ______________________ Location: ______________ Last visit: ________

Orthopedist: ______________________ Location: ______________ Last visit: ________

Cardiologist: ______________________ Location: ______________ Last visit: ________

Dermatologist: ______________________ Location: ______________ Last visit: ________

Gastroenterologist: ______________________ Location: ______________ Last visit: ________

Endocrinologist: ______________________ Location: ______________ Last visit: ________

Pulmonologist: ______________________ Location: ______________ Last visit: ________

Patient Name: ____ DOB: __________

Other Pertinent Medical Information You Would Like To Share With Us?

____

____

____

____

____

X ______________________________________ ________________________

Patient Signature *Date*

X ______________________________________ ________________________

Parental/Guardian Signature *Date*

_______________________________________ ________________________

Signature of Reviewing Provider *Date*