SOUTHERN INDIANA COMMUNITY HEALTHCARE
COMPREHENSIVE HEALTHCARE
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:** ______________

Gender: ☐Male ☐ Female ☐Transgender/Male to Female ☐ Transgender/ Female to Male ☐Other
Age: ________ **DOB:** ____________ **Email:** ______________________
(Access Health Record 24 hrs. 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: ______________________
Ethnicity ☐ Non-Hispanic or Latino ☐ Hispanic/Latino
Patient Employed By: ______________________ **Occupation:** ______________

Billing Address: ______________________ **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: ______________________

***If under 18 please list both biological Parents ***

Mother: ______________________ **Phone Number:** ______________

Father: ______________________ **Phone Number:** ______________

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 SICHC 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

____
Signature of Insured/Guardian Date

Patient Name: ____ **DOB:** ________________________

Social History

The following questions may seem difficult to answer, but are important for us to know, so we can properly screen all our patients for their health care needs.

Are you a seasonal worker? ☐Yes ☐No
Are you a migrant worker? ☐Yes ☐No
Are you a Veteran? ☐Yes ☐No
Are you homeless? ☐Yes ☐No
Do you live in public housing? ☐Yes ☐No (Housing provided for people with low income)
What is your sexual orientation? ☐Straight (not lesbian or gay) ☐Lesbian or Gay ☐Bisexual ☐Do not know

Past Medical History: Have you ever been diagnosed with any of the following **Please Check Box**

☐ **Alcohol or Drug Addition**	☐ **Asthma**	☐ **Bleeding/Clotting Tendencies**	☐ **Cancer Type:** ____________________	☐ **Chronic Pain Location:** __________________
☐ **Birth Defect**	☐ **COPD/ Emphysema**	☐ **Depression**	☐ **Diabetes Diagnosed** ________ **A1C** _____________	☐ **Acid Reflux**
☐ **Genital/Bladder Disease**	☐ **Heart Attack**	☐ **Heart Disease**	☐ **High Blood Pressure**	☐ **Liver Disease**
☐ **Mononucleosis**	☐ **Neurologic Disease**	☐ **Renal/Kidney Disease**	☐ **Rheumatic Fever**	☐ **Sleeping Disorder**
	☐ **Seizures**	☐ **Stomach Ulcers**	☐ **Tuberculosis**	

Medication:

<u>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:** _______________
Name: ____________________________ **Dose:** _______________ **Frequency:** _______________
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Name: ____________________________ **Dose:** _______________ **Frequency:** _______________

Hospital/Surgical History:

Explain: ____
Date: _______________ **Facility:** ______________________________________
Explain: ____
Date: _______________ **Facility:** ______________________________________
Explain: ____
Date: _______________ **Facility:** ______________________________________
Explain: ____
Date: _______________ **Facility:** ______________________________________

Patient Name: ______________________________ DOB: ______________

Allergies:

1) Medication: ______________________ Reaction: ______________________
2) Medication: ______________________ Reaction: ______________________
3) Medication: ______________________ Reaction: ______________________
4) Environmental: ____
5) Food: ____

Habits:

Do you exercise? ☐ Yes ☐ No Type/Frequency: ______________________

Do you smoke? ☐ Yes ☐ No How Much/Often: _________ ☐ Former Smoker ☐ Never Smoker

Drink alcohol? ☐ Yes ☐ No How Much/Often: _________ Quit ☐ Yes ☐ No Date: ___________

Drugs Use? ☐ Yes ☐ No How Much/Often: _________ 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 your last menstrual period? _________________________

Number of Pregnancies: _________________________

Number of Births: _________________________

Last pap/GYN exam approx. Date: ____________ History of Abnormal? ☐ Yes ☐ No

Preformed by: _________________________

Age of Menopause: ________________ N/A

Last mammogram: ________________ N/A

Hysterectomy ☐ Yes ☐ No Date ____________ Reason ____________

Health Maintenance

Last Colonoscopy: _______________ ☐ Normal ☐ Abnormal

Colonoscopy Preformed by: _______________

Last DEXA Scan: _______________

Last Dilated Eye Exam: _______________

Do you have Advanced Directives?

Living Will ☐ Yes ☐ No

Durable Power of Attorney ☐ Yes ☐ No

Would you like information on creating a living will? ☐ Yes ☐ No

Patient Name: ____ DOB: ________________________

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

Anxiety	☐	PGF	PGM	MGF	MGM	M	F	B	S
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
Coronary Artery Disease	☐	PGF	PGM	MGF	MGM	M	F	B	S
Depression	☐	PGF	PGM	MGF	MGM	M	F	B	S
Diabetes	☐	PGF	PGM	MGF	MGM	M	F	B	S
Gastric Rflux	☐	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

Please list any other health care providers (i.e. Dentist, GYN, Cardio, etc.) Be sure to include the provider name and location.

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Other Pertinent Medical Information you would like to share with us?

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X ____ ______________________________
Patient Signature **Date**

X ____ ______________________________
Parental/Guardian Signature **Date**

X ____ ______________________________
Signature of Reviewing Provider **Date**