



Proudly Serving Four (4) Locations:

Comprehensive Health Care, Paoli 812.723.3944 (F) 812.723.7989
Crawford Co Family Health, Marengo 812.365.3221 (F) 812.365.9502
Patoka Family Health, English 812.338.2924 (F) 812.338.3706
Valley Health, West Baden 812.723.7125 (F) 812.936.2599

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 (Non Hispanic or Latino) Native Hawaiian Other Pacific Islander American Indian/Alaska Native
Black/African American (Non Hispanic or Latino) Asian More than one race Unreported/Refused to Report

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 SICHHC 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 SICHHC 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/Income Assistance

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. Additionally, we have many programs to provide financial assistance and appreciate your answers to the below questions.

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)

Household Size: 1 2 3 4 5 6 or more

Household Income \$0 - \$20,000 \$20,001 - \$35,000 \$35,001 - \$45,000

\$45,001 - \$60,000 \$60,001 & Over Decline to Answer

Does your insurance pay for prescriptions? Yes No

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

<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding/Clotting Tendencies	<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Chronic Pain Location: _____
<input type="checkbox"/> Birth Defect	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes Diagnosed _____ A1C _____	<input type="checkbox"/> Acid Reflux	
<input type="checkbox"/> Genital/Bladder Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Neurologic Disease	<input type="checkbox"/> Renal/Kidney Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sleeping Disorder	
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Tuberculosis		

Medication:

****Please Include all medications, including over the counter and supplements.**

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

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

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) 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: _____
- Shingles _____ Date: _____
- COVID-19 _____ Date(s): _____

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
- Performed by: _____
- Age of Menopause: _____ N/A
- Last mammogram: _____ N/A
- Hysterectomy Yes No Date _____ Reason _____

Health Maintenance

- Last Colonoscopy: _____ Normal Abnormal
- Colonoscopy Performed 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	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Arthritis	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Asthma	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Cancer Type: _____	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Coronary Artery Disease	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Depression	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Diabetes	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Gastric Rflux	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Heart Attack	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
High Cholesterol	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Hypertension/High Blood Pressure	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Migraines	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Obesity	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Stomach Ulcers	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Stroke	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Other: _____	<input type="checkbox"/>	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's name and location.

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

X _____
 Patient Signature

 Date

X _____
 Parental/Guardian Signature

 Date

X _____
 Signature of Reviewing Provider

 Date