PAOLI · MARENGO · WEST BADEN · ENGLISH · SHOALS · SALEM · BEDFORD · MITCHELL

NEW PATIENT FORM (18+)

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 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/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**

☐ **Alcohol Addiction**	☐ **Drug Addiction**	☐ **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:** ____________
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

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's 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**