SOUTHERN INDIANA Community Health Care

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

PEDIATRIC NEW PATIENT FORM

Patient: _____
Last Name First Name Middle Initial Social Security #

Mailing Address _____

City: _____ State: _____ Zip: _____ Language: ☐ English ☐ Spanish ☐ Other

Home Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female ☐ Transgender/Male to Female ☐ Transgender/ Female to Male ☐ Other

Age: _____ DOB: _____ Email: _____
(For Access to Health Records 24 hrs. a day, 7 Days a Week)

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

Does the Patient 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 all Parents/Guardians

Parent/Guardian: _____ Phone Number: _____

Parent/Guardian: _____ 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

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 ☐

Past Medical History

Has the patient ever been diagnosed with any of the following: Please Check Box

☐ Seizures	☐ Asthma	☐ Frequent Ear Infections	☐ Cancer Type: _____	☐ Dizziness/ Fainting
☐ ADHD	☐ Migraines/ Headaches	☐ Depression	☐ Diabetes Insulin_____ A1C _____	☐ Anxiety
☐ Bladder Infections	☐ Eczema/ Rashes	☐ Heart Condition	☐ Behavioral Challenges	
☐ Other				

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:_____

Hospital/Surgical History

Explain:_____
Date:_____ Facility:_____
Explain:_____
Date:_____ Facility:_____

Allergies:

1) Medication:_____ Reaction: _____
2) Medication:_____ Reaction: _____
3) Medication:_____ Reaction: _____
4) Environmental: _____
5) Food: _____

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