SOUTHERN INDIANA Community Health Care

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

www.sichc.org

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

INSURANCE 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 or other payer 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.

_____

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.

1. Are you a seasonal worker? ☐ Yes ☐ No
2. Are you a migrant worker? ☐ Yes ☐ No
3. Are you a Veteran? ☐ Yes ☐ No
4. Are you homeless? ☐ Yes ☐ No
5. Do you live in public housing? ☐ Yes ☐ No (Housing provided for people with low income)
6. Household Size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more
7. Household Income ☐ $0 - $20,000 ☐ $20,001 - $35,000 ☐ $35,001 – $45,000 ☐ $45,001 – $60,000 ☐ $60,001 & Over ☐Decline to Answer
8. Does your insurance pay for prescriptions? ☐ Yes ☐ No
9. 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:

****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 Quit:_____

Drink alcohol? ☐ Yes ☐ No How Much/Often:_____ ☐ Former Drinker Quit:_____

Drugs Use? ☐ Yes ☐ No How Much/Often: _____ ☐ Former User Quit:_____

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.

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

X _____ _____

Patient Signature **Date**

X _____ _____

Parental/Guardian Signature **Date**