Patient Name: _____ _____ ____ Date Of Birth: _____
Last Name First Name M.I. mm/dd/yyyy

Social Security Number:_____

Home Phone:_____Cell Phone:_____

Sex assigned at birth: ☐Male ☐Female

Gender Identity: ☐Male ☐Female ☐Transgender Male / Female to Male
☐Transgender Female / Male to Female ☐Other ☐Choose not to disclose

Sexual Orientation: ☐Lesbian or Gay ☐Straight (not lesbian/gay) ☐Bisexual
☐Something else ☐Don't know ☐Choose not to disclose

Address:_____
(Street Address) (City) (State) (Zip)

Mailing Address (if different):_____
(Street Address) (City) (State) (Zip)

Appointment reminders / Confirmations / Special Notices / Sharing Information

Email and text messaging allows us to exchange information efficiently. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly during transmission. If you would like us to send email and/or text messages that contains your health information, please provide the following information to authorize CCHD to communicate with you and other health care providers for your medical care and treatment.

** Complete the following only if email / text correspondence is being authorized:

Email to send me information:_____

Phone Number to send me texts: _____

*****If you prefer not to authorize the use of email / text messaging we will continue to use U.S. Mail or telephone to communicate with you.

YOUR PRIMARY CARE DOCTOR IS:_____☐Dr. Royeen ☐Dr. Curry ☐Emily Eichelberger

NP **YOUR DENTIST IS:**_____ ☐Dr. Watson ☐Dr. Johnson ☐Dr. Buskirk

PREFERRED PHARMACY IS:_____@ Town/City _____

Ethnicity
☐Not Hispanic / Not Latino
☐Hispanic / Latino
☐Unknown / Not Reported

Race
☐American Indian/Alaska Native ☐Asian
☐Black/African American ☐White
☐More than one race ☐Native Hawaiian
☐Other Pacific Islander ☐Declined

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed

Are you a: Student? ☐No ☐Yes **Veteran?** ☐No ☐Yes **Migrant Worker?** ☐No ☐Yes

Housing: ☐Own ☐Rent ☐Income Based / Public Housing ☐Living with Friends / Family ☐Homeless

What is the approximate annual household income?_____Family Size____☐ Refused to Report

Does patient need an interpreter? ☐No ☐Yes **-**Spanish / French / Sign Language

If patient is under the age of 18 does the parent/guardian need an interpreter?
☐No ☐Yes **-**Spanish / French / Sign Language

Does patient have a Power of Attorney For Healthcare/ Advance Directive / Do-Not-Resuscitate order / Court Ordered Guardian? ☐No ☐Yes *If yes please provide us with a copy.

EMERGENCY CONTACT INFORMATION:

NAME:_____

Relationship:_____Phone Number:_____

RESPONSIBLE PARTY INFORMATION *Person to be billed if other than patient

First Name:_____MI:_____Last Name:_____Suffix:_____

Social Security Number:_____Date of Birth: _____ (mm/dd/yyyy) Sex: ☐ Male ☐Female

Address:_____
(Address) (City) (State) (Zip)

Phone Number: _____

All clients have the right to treatment by the Cass County Health Department (CCHD) without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

The above information is true and correct to my knowledge.

I accept full responsibility for my/my child's care and treatment and release the CCHD and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment.

I authorize the CCHD to provide service to me and to release necessary information to bill, process and receive payment of Medical / Dental Benefits (private insurance, Medicare, or Medicaid, etc.), for Medical and Professional Services Rendered.

PATIENT RIGHTS AND RESPONSIBILITIES: I understand it is my responsibility to read and follow the information contained in this notice. All clients have the right to treatment by CCHD without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

NOTICE OF PRIVACY PRACTICES: My signature below also indicates that I have been offered a copy of CCHD's "Notice of Privacy Practices." I understand it is my responsibility to ask any questions I may have.

Client (or Parent) Signature:_____ *Typed name creates your digital signature **Date:**_____ (mm/dd/yyyy)

How did you hear about us? ☐Newspaper ☐Friend/Family ☐Billboard ☐Radio ☐Other_____

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

Thank you for choosing Cass County Health / Dental / Behavioral Health Clinic for your medical / dental and behavioral health care. Our staff values your time and we hope you will, in turn, value ours. In order to serve you better we have the following office policies for you to review and sign. Agreeing to these policies will enable us to provide better care to you in a timely and efficient manner.

PAYMENT

- All payments / copays for services performed are due at the time of service
- Eligibility for services under Illinois Medicaid will be determined prior to the start of each visit.
- You must bring your current insurance card for each appointment. If eligibility cannot be verified, you will be required to pay for the service.
- Any services not covered by Medicaid, Medicare and/or medical / dental insurance will be your responsibility to pay.
- A patient with a past due balance will be required to consult with our billing office to set up a payment plan to pay off the past due amount.
- I understand if my account is referred to a Collection Agency I will be responsible for Collection costs incurred.

SLIDING FEE SCHEDULE

- We offer a sliding fee plan to allow patients who have provided proof of income to receive services at an affordable fee. Your fee is determined by the income and size of your family.
- The sliding fee schedule is based on the United States Department of Health and Human Services Guidelines.

APPOINTMENTS

- It is your responsibility to remember your appointment. In order for us to provide a courtesy call, a current contact phone number is required. It is your responsibility to inform us of any changes.
- Staff will call to confirm appointments. You must answer, or call us back within 24 hours, or your appointment will be cancelled.
- If your phone number is disconnected or not updated or your voicemail is not working, your appointment may be filled with another patient.
- New patients will be asked to show up to their appointment 30 minutes prior to the start of their appointment to complete new patient paperwork.

TREATMENT OF MINORS

All minors must be accompanied by a legal guardian or a legal guardian must give written permission for another individual to accompany them by completing the required Proxy Form. Depending on the treatment to be provided a legal guardian may be required to be on site to give informed consent except in cases where minors may seek care as allowed by Illinois state law.

PATIENT CENTERED MEDICAL HOME

A patient centered medical home is a system of care in which a team of health professionals work together to provide all of your health care needs. We use technology such as electronic medical records to communicate and coordinate your care and provide the best possible outcomes for you. You, the patient, are the most important part of the patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need!

I understand and agree to the above written policies.

mm/dd/yyyy

* Typed name creates an electronic signature

Signature **Date**

Consent to Release Information to Designated Family Member or Caregiver

The names listed below are allowed to have information released to them from Cass County Health Department with the undersigned consent.

Name	Relationship	Phone
Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**

mm/dd/yyyy

☒ **Signature**_____ * Typed name creates an electronic signature. **Date**_____

*This consent may be revoked at any time upon written request.

Please complete this form if you are a Medicare Patient

MEDICARE PATIENTS -MSP

I am receiving Medicare based on: ☐ Age ☐ Disability ☐ End Stage Renal Disease

I am currently employed: ☐No ☐Yes
Name and address of my Employer_____

I have a spouse who is currently employed: ☐No ☐Yes
Name and address of spouse's Employer_____

Do you have Group Health Plan on your own or your spouse's current employment?
☐No ☐Yes-Both ☐Yes-Self ☐Yes-Spouse

MEDICARE LIFETIME SIGNATURE FORM STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO CASS COUNTY HEALTH DEPARTMENT

I request payment of authorized Medicare benefits or on my behalf for any services furnished me by The Cass County Health Department. I authorize any holder of medical and other information about me to be released to Medicare and its agents any information needed to determine these benefits or benefits for related services.

* Typed name creates an electronic signature

⇨**Patient Signature:**_____**Date:**_____mm/dd/yyyy

OR if patient is unable to sign Please Print:

_____ ⇨ * Typed name creates an electronic signature _____ mm/dd/yyyy

PRINT Representative / Parent / Guardian Name AND RELATIONSHIP | **Signature Representative / Parent / Guardian** | **Date**

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Previous Or Referring Doctor:		**Date Of Last Physical Exam:**	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESSES:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
IMMUNIZATIONS AND DATES:	☐ Influenza	☐ Td	☐ Pneumonia	☐ Hepatitis B
HEALTH SCREENINGS	☐ Colonoscopy When/Where:		☐ Chest XRay When/Where:	
	☐ Rectal Exam/Blood When/Where:		☐ EKG When/Where:	

LIST MEDICAL PROBLEMS OTHER DOCTORS HAVE DIAGNOSED

Diabetes	□ Yes □ No	Arthritis / Gout	□ Yes □ No	Epilepsy	□ Yes □ No	Bleeding disorder	□ Yes □ No
Anemia	□ Yes □ No	High Blood Pressure	□ Yes □ No	Hepatitis	□ Yes □ No	Cataracts	□ Yes □ No
Cancer	□ Yes □ No	Heart Problems	□ Yes □ No	Blood Clots	□ Yes □ No	Thyroid Problems	□ Yes □ No
Stroke	□ Yes □ No	Antibiotic Resistant Infections	□ Yes □ No	Lupus	□ Yes □ No	Tuberculosis	□ Yes □ No
Asthma	□ Yes □ No	Sexually Transmitted Disease	□ Yes □ No	Glaucoma	□ Yes □ No	High Cholesterol	□ Yes □ No
COPD	□ Yes □ No	Congestive Heart Failure	□ Yes □ No	Depression	□ Yes □ No		
Other							

SURGERIES & OTHER HOSPITALIZATIONS

Year	List Surgery	Hospital

LIST YOUR PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS AND INHALERS

Drug Name	Strength	How often?	Drug Name?	Strength	How often?

ALLERGIES (MEDICATIONS, FOOD, SEASONAL OR ENVIRONMENTAL)

Allergy to what?	Reaction?	Allergy to what?	Reaction?	Allergy to what?	Reaction?

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes ☐ No
	If yes, what kind? How many drinks per week?	
Caffeine	Do you use caffeine?	☐ Yes ☐ No
	If yes, what kind? ☐Chocolate ☐Coffee ☐Tea ☐Soda ☐Energy Drink ☐Tablet	
Tobacco	Do you use tobacco?	☐ Yes ☐ No
	☐ Cigarettes pks. day ☐ Chew day ☐ Pipe day ☐ Cigars day	
	# of years Or year quit	
Drugs	Do you currently or have you ever used recreational or street drugs? Type/Frequency_____	☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes ☐ No
Tattoos	Do you have any tattoos?	☐ Yes ☐ No
Diet	Diet ☐ Regular ☐ Diabetic ☐ Low Salt / Low Sodium ☐ Low Fat ☐ Other _____	
Exercise	Exercise -Describe_____	☐ Yes ☐ No

CONSTITUTIONAL SYMPTOMS

Poor health lately	Yes	No
Recent weight change	Yes	No
Fatigue/ Tiredness	Yes	No

EYES

Eye Disease / Injury	Yes	No
Glasses / Contacts	Yes	No
Blurring	Yes	No
Double Vision	Yes	No

EAR / NOSE / MOUTH / THROAT

Hearing loss / Ringing in ears	Yes	No
Ear ache or drainage	Yes	No
Chronic Sinus Problems	Yes	No
Nosebleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath / bad taste	Yes	No
Sore Throat	Yes	No
Swollen glands in neck	Yes	No

CARDIOVASCULAR

Chest Pain / Angina	Yes	No
Palpitations (Irregular heartbeat)	Yes	No
Shortness of Breath	Yes	No
Swelling of Feet	Yes	No

RESPIRATORY

Chronic / Frequent Cough	Yes	No
Coughing up blood	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No

GASTROINTESTINAL

Loss of appetite	Yes	No
Change in bowel movements (poop)	Yes	No
Nausea or Vomiting	Yes	No
Frequent Diarrhea	Yes	No
Painful bowel movements / Constipation	Yes	No
Rectal / Butt Bleeding	Yes	No
Abdominal Pain / Heartburn	Yes	No

GENITOURINARY

Frequent Urination (pee)	Yes	No
Burning / Painful Urination (peeing)	Yes	No
Blood in urine (pee)	Yes	No
Incontinence (Wetting underpants) / Dribbling	Yes	No
Kidney Stones	Yes	No
Sexual Problems	Yes	No

MUSCULOSKELETAL

Joint Pain	Yes	No
Joint stiffness / swelling	Yes	No
Weakness of muscles	Yes	No
Muscle Pain / Cramps	Yes	No
Back Pain	Yes	No
Cold hands or fingers / feet or toes	Yes	No

INTEGUMENTARY

Rash or Itching	Yes	No
Change in skin color	Yes	No
Change in hair or fingernails	Yes	No
Varicose veins	Yes	No
Excessive moles	Yes	No
Excessive exposure to sun	Yes	No
Lesions or Sores	Yes	No

NEUROLOGICAL

Frequent headaches	Yes	No
Lightheaded / Dizzy	Yes	No
Convulsions / Seizures	Yes	No
Numbness / Tingling	Yes	No
Tremors / Shakes	Yes	No
Paralysis	Yes	No
Head Injury	Yes	No

PSYCHIATRIC

Memory Loss / Confusion	Yes	No
Nervousness / Anxiety	Yes	No
Sadness	Yes	No
Insomnia / Unable to sleep	Yes	No

ENDOCRINE

Gland or Hormone Problems	Yes	No
Skin becoming drier	Yes	No
Excessive thirst or urination	Yes	No
Get too cold / get too hot (hot flashes, etc)	Yes	No

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts / injury	Yes	No
Bleeding / Bruising easily	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past blood transfusions	Yes	No
Enlarged glands	Yes	No

OTHER

FAMILY HISTORY

	Health Problems	Age	Deceased		Cause of Death		Health Problems	Age	Deceased		Cause of Death
Father			Yes	No		Children		☐M ☐F	Yes	No	
Mother			Yes	No		Children		☐M ☐F	Yes	No	
Siblings		☐M ☐F	Yes	No		Children		☐M ☐F	Yes	No	
Siblings		☐M ☐F	Yes	No		Children		☐M ☐F	Yes	No	
Siblings		☐M ☐F	Yes	No		Grandmother Maternal			Yes	No	
Siblings		☐M ☐F	Yes	No		Grandfather Maternal			Yes	No	
Siblings		☐M ☐F	Yes	No		Grandmother Paternal			Yes	No	
Siblings		☐M ☐F	Yes	No		Grandfather Paternal			Yes	No	

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes ☐ No
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning discharge from penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erection or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No
Date of last prostate and rectal exam?	☐ Yes ☐ No
Are you sexually active? If yes with Male/Female/Both?- Please circle	☐ Yes ☐ No
Have you had more than one sexual partner in the past year?	☐ Yes ☐ No

Number of pregnancies_____Number of live births_____Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes ☐ No
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No
Vaginal Discharge?	☐ Yes ☐ No
Are you sexually active? If yes with Male Female Both?-	☐ Yes ☐ No
Have you had more than one sexual partner in the past year?	☐ Yes ☐ No