PATIENT NAME: _____ ___ _____ **DOB:** ____ / ____ / _____
First MI Last mm/dd/yyyy

Social Security Number: ____-____-____ Home Phone: _____

Cell Phone: _____ Alternate 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

To authorize us to send email and/or text messages that may contain your health information, to you or other health care providers, please provide the following information. Email and text messaging are not a completely secure means of communication because they may be addressed to the wrong person or accessed improperly during transmission.

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: _____ ☐ Cass County Dental Clinic ☐ Other

PREFERRED PHARMACY IS: _____ @ _____

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

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

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

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

Are you homeless? ☐ No ☐ Yes

What is the approximate annual household income? _____ Family Size __ ☐ Refused to Report

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

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: _____

PATIENT NAME: _____ ___ _____ **DOB:**_____ / ____ / _____
First MI Last mm/dd/yyyy

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

First Name: _____ MI: _____ Last Name: _____ Suffix: ____

Social Security Number: ____ - ___ - _____ Date of Birth: ___ / ___ / ____ Sex: ☐ Male ☐ Female

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

Phone Number: _____

INSURANCE INFORMATION: Check all that apply

☐ Medicaid ☐ Allkids ☐ Medicare ☐ Private Insurance ☐ Self pay ☐ Sliding Fee

Name of Policy Holder: _____ Date of Birth: _____

Social Security Number of Policy Holder: _____

Place of Employment: _____

Name of **Medical Insurance**: _____ Policy Number: _____

Group Number: _____ Effective Date: _____

Name of **Dental Insurance**: _____ Policy Number: _____

Group Number: _____ Effective Date: _____

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 NAME: _____ ___ _____ **DOB:** ____ / ____ / _____
First MI Last mm/dd/yyyy

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.

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
Name	Relationship	Phone

☒ **Patient / Parent Signature:** _____ **Date:** _____

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

PATIENT NAME: _____ ___ _____ **DOB:** ____ / ____ / _____
First MI Last mm/dd/yyyy

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.

_____ _____
Signature **Date**

DATE:_____ **MEDICAL HISTORY**

PATIENT'S NAME:_____ BIRTHDATE:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◊ No ◊ Yes _____

Have you ever been hospitalized or had major operation? ◊ No ◊ Yes _____

Have you ever had a serious head or neck injury? ◊ No ◊ Yes _____

Are you taking any medications? ◊ No ◊ Yes _____

Do you take, or have you taken Phen-Fen, Redux? ◊ No ◊ Yes

Are you or have you ever taken, Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◊ No ◊ Yes

Are you on a special diet? ◊ No ◊ Yes

Do you use tobacco? ◊ No ◊ Yes

Do you use controlled substances? ◊ No ◊ Yes

Women, Are you:

Pregnant/Trying to Get Pregnant ◊ No ◊ Yes Taking Oral Contraceptives ◊ No ◊ Yes Nursing ◊ No ◊ Yes

Are you allergic to any of the following?:

◊Aspirin ◊Penicillin ◊Codeine ◊Acrylic ◊Metal ◊Latex ◊Local Anesthetics

◊Food -If yes, please explain:_____

◊Other-If yes, please explain:_____

◊I have no known allergies

Do you have, or have you had, any of the following:

AIDS/HIV Positive	◊ Yes	Cortisone Medicine	◊ Yes	Hemophilia	◊ Yes	Radiation Treatments	◊ Yes
Alzheimer's Disease	◊ Yes	Diabetes	◊ Yes	Hepatitis A	◊ Yes	Recent Weight Loss	◊ Yes
Anaphylaxis	◊ Yes	Drug Addiction	◊ Yes	Hepatitis B or C	◊ Yes	Renal Dialysis	◊ Yes
Anemia	◊ Yes	Easily Winded	◊ Yes	Herpes	◊ Yes	Rheumatic Fever	◊ Yes
Angina	◊ Yes	Emphysema	◊ Yes	High Blood Pressure	◊ Yes	Rheumatism	◊ Yes
Arthritis/Gout	◊ Yes	Epilepsy or Seizures	◊ Yes	High Cholesterol	◊ Yes	Scarlet Fever	◊ Yes
Artificial Heart Valve	◊ Yes	Excessive Bleeding	◊ Yes	Hives or Rash	◊ Yes	Shingles	◊ Yes
Artificial Joint	◊ Yes	Excessive Thirst	◊ Yes	Hypoglycemia	◊ Yes	Sickle Cell Disease	◊ Yes
Asthma	◊ Yes	Fainting Spells/Dizziness	◊ Yes	Irregular Heartbeat	◊ Yes	Sinus Trouble	◊ Yes
Blood Disease	◊ Yes	Frequent Cough	◊ Yes	Kidney Problems	◊ Yes	Spina Bifida	◊ Yes
Blood Transfusion	◊ Yes	Frequent Diarrhea	◊ Yes	Leukemia	◊ Yes	Stomach/Intestinal Disease	◊ Yes
Breathing Problem	◊ Yes	Frequent Headaches	◊ Yes	Liver Disease	◊ Yes	Stroke	◊ Yes
Bruise Easily	◊ Yes	Genital Herpes	◊ Yes	Low Blood Pressure	◊ Yes	Swelling of Limbs	◊ Yes
Cancer	◊ Yes	Glaucoma	◊ Yes	Lung Disease	◊ Yes	Thyroid Disease	◊ Yes
Chemotherapy	◊ Yes	Hay Fever	◊ Yes	Mitral Valve Prolapse	◊ Yes	Tonsillitis	◊ Yes
Chest Pains	◊ Yes	Heart Attack/Failure	◊ Yes	Osteoporosis	◊ Yes	Tuberculosis	◊ Yes
Cold Sores/Fever Blisters	◊ Yes	Heart Murmur	◊ Yes	Pain in Jaw Joints	◊ Yes	Tumors or Growths	◊ Yes
Congenital Heart Disorder	◊ Yes	Heart Pacemaker	◊ Yes	Parathyroid Disease	◊ Yes	Ulcers	◊ Yes
Convulsions	◊ Yes	Heart Trouble/Disease	◊ Yes	Psychiatric Care	◊ Yes	Venereal Disease	◊ Yes
						Yellow Jaundice	◊ Yes

***Have you ever had any serious illness not listed above?* ◊ Yes ◊ No**

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____ DATE:_____

PATIENT NAME: _____ ___ _____ **DOB:** ____ / ____ / _____
First MI Last mm/dd/yyyy

School Grade is: ☐

☐ A/C Elementary ☐ A/C Jr. High ☐ A/C HS ☐ Beardstown HS
☐ Beardstown Grand ☐ Beardstown Gard ☐ Beardstown Jr. High ☐ BCA
☐ Virginia Elementary ☐ Virginia Jr. High ☐ Virginia HS ☐ Alternative School
☐ Pre-school or Other _____

***Does this child live in Cass County?** ☐No ☐Yes

***Does this child attend a Cass County School?** ☐No ☐Yes
***Is this child a brother or sister of a child attending a school in Cass County?** ☐No ☐Yes

Mother's Maiden Name:_____

I, as the authorized representative/ parent/ guardian of this patient, authorize the following person(s) to transport, accompany, authorize, and consent to any x-ray, exam, medical, dental, psychiatric, or psychological diagnosis or treatment to be rendered by CCHC/CCDC staff. All providers may discuss patient's care with those listed below.

Initials	*Proxy Name*	*Relationship to Patient*	*Phone#*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____This patient (if 12 years or older) may present and receive diagnosis, treatment, and instruction without additional supervision
Initials

_____Myself ONLY
Initials

105 ILCS 129: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2935&ChapterID=17

The School Health Center Act -*Requires the SHC to list the available services, giving parent the option to opt out of certain services. Minor Consent laws still apply.*

The Cass County School Health Center (CCSHC) consists of a seamless partnership of trusted local agencies dedicated to the health and well-being of your child. The partnership includes; A Physician, Nurse Practitioner or Physician Assistant, Dentist, Dental Hygienist, Nurse and Mental Health Counselor are available, based on schedules, to provide primary health care, dental care, psychosocial services and nutritional consultation to ALL students enrolled.

Available services may include, but are not limited to:

1. Physical examination, health assessments, screening for health problems
2. Diagnosis and treatment of acute illness and injury
3. Diagnosis and management of chronic illness
4. Health education and promotion. Outreach health promotion /prevention workshops will be offered
5. Immunizations
6. Wellness promotion including smoking cessation, nutrition, weight management
7. Reproductive health care including: gynecological examinations with PAP smears, STD education, testing, and treatment, HIV/AIDS education, counseling / testing, and contraceptive services
8. Laboratory tests including throat cultures, complete blood counts, mono spots etc.
9. Mental Health counseling services
10. Dental examination and treatment
11. Referrals to other linkage agencies for services not provided at Cass County School Health Center

410 ILCS 210/1, *et seq.* http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1539&ChapterID=35

PARENTAL/GUARDIAN CONSENT

The aforementioned child has my consent to receive services offered at the Cass County School Health Center (CCSHC) located in Cass County Illinois, by its contracted providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care services. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing the Health Center to provide services to my child in his/her best interest.

I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services.

I consent to the release of relevant health information and medical records in connection with treatments to the School Health Center and its collaborating partners to facilitate my child's health needs. I further authorize the School Health Center to release information regarding my child's treatment to third party payors or others for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

I understand that if my child is 12 or older they can receive mental health/substance abuse services at the CCSHC without my consent. Per 405 ILCS 5/3-5A-105(a), they may receive up to eight 90-minute sessions for mental health services. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

This authorization will remain in effect unless specifically revoked in writing.

⇨_____ _____
Representative / Parent Guardian Signature **Date**

Office Use Only: ☐Certification of Unaccompanied Minor Status

Cass County Health Department Authorization
Departamento de Salud del Condado de Cass Autorización
Cass County Health Department Authorization

Patient's Name - PLEASE PRINT El Nombre del Paciente Nom du Patient – LETTRE MOULÉES	**Patient's Date of Birth** Fecha de Nacimiento del Paciente Date de naissance du patient	**Patient's Street Address** La Dirección del Pacient Adresse du Patient	**City** Ville	**State** État	**Zip Code** Code postal
	___/___/___				

I hereby authorize the use or disclosure of protected health information about me as described below.
Yo por la presente autorizo el uso y revelación de la información protegida de salud acerca de mí describieron como abajo.
Par la présente, j'autorise l'utilisation ou divulgation d'informations protégées sur ma santé tel que décrit ci-dessous.

I authorize Cass County Health Department to disclose:
Yo doy autorización al Departamento de Salud del Condado de Cass para revelar información acerca de los siguientes:
J'autorise le Cass County Health Department à divulguer:
- √ **Physical / Dental Exam**; Examen Físico / Dental; Examen physique / dentaire
- √ **TB Skin Test**; Prueba Tuberculosis; Test sur la tuberculose
- √ **Vision / Hearing Screen**; Exam Vista/ del Oido; Test de la vue / d'audition
- √ **Lead Screen**; Examen del Plomo; Test de plomb √ **Immunization Record**; Vacunas; Carnet de vaccination
- √ **Hemoglobin /Hematocrit test**; Cheque del hierro en su sangre; Test d'hémoglobine /hématocrite
- √ **Appt Date & Time**; Fecha/Hora de las citas; Date de rendez-vous & Heure √ **Other**; Otros; Autre:_____

TO: (check one); Información puede ser revelada a: (cheque uno); À: (check one) ❒**A-C Central School District**; Distrito de la Escuela de A-C Central ❒**Beardstown Christian Academy**; Escuela de Beardstown Christian Academy ❒**Beardstown School District**; Distrito de la Escuela de Beardstown ❒**Trinity Lutheran School**; Escuela de Trinity Lutheran ❒**Virginia School District**; Distrito de la Escuela de Virginia ❒**Other**; Otros; Autre _____

The information may be used or disclosed for each of the following purposes: For the maintenance of school records / Verification of excused absences
Esta información puede usarse y ser revelada para cada uno de los propósitos siguientes: Para conservar los registros de escuela / Para comprobar la ausencia dispensada de la escuela
L'information peut être utilisée ou divulguée dans le but suivant: Pour la mise à jour des dossiers scolaires /Pour la verification d'absences

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.
Entiendo que la información usada o revelada puede ser revelado otra vez por la persona(s) o la clase de persona(s) lo receibiendo y que no protegido por las regulaciones federales de la confidencialidad.
Je comprends que l'information utilisée ou divulguée peut être sujet à une re-divulgation par la (les) personne(s) ou classe de(s) personne(s) recevant ces informations et ne sera plus protégé par les régulations fédérales privées.

I understand that I may revoke this authorization by notifying the Privacy Officer in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Cass County Health Department in reliance on it before I revoked it.
Entiendo que puedo revocar esta autorización notificando al Oficial de la Confidencialidad al escribirle de mi deseo para revocarlo. Sin embargo, yo entiendo que si revoco esta autorización, no tendrá ningún afecto en acciones tomadas por el Departamento de Salud antes de yo lo revoqué
Je comprends que je peux révoquer cette autorisation en avisant l'Officier sur la vie privée par écrit . Toutefois, Je comprends que si je révoque cette autorisation, il n'y aura aucune conséquence sur les actions prises par le
Cass County Health Department en dépendance avant révocation.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
Entiendo que puedo negarme a firmar esta autorización y que al negarme no afectará mi habilidad de obtener el tratamiento, ni el pago, ni mi elegibilidad para beneficios.
Je comprends que je peux refuser de signer cette autorisation et que mon refus de signer n'affectera pas mon abilité d'être traité ou paiement ou mon éligibilité pour avantages.

I understand this authorization will expire on (check and complete one): ❒_____,20___,or √ Upon withdrawal from school or high school graduation.
Entiendo que la autorización expirará en (cheque y completará uno): ❒_____,20___,or √ En el acontecimiento de la graduación de la preparatoria, la terminación del nivel más alto del grado ofreció (para esos no ofreciendo graduación de la preparatoria), o dejan de asistir en la escuela.
Je comprends que cette autorisation expirera (cochez et complétez):❒ ____,20___,ou √-Lors du retrait de l'étudiant (enfant) de l'école ou lors de la graduation.

This form must be fully completed before signing
Esta forma debe ser completada antes de firmar
Ce formulaire doit être complété complètement avant d'être signé

☒_____

Signature of Patient **or Legal Guardian** La Firma del Paciente o **Representante Personal** Signature du Patient **ou Gardien legal**	Date of Signature La Fecha de la Firma Date de la signature	PLEASE PRINT Name of Person Signing this Authorization **if not Patient** Nombre del Representante Personal(Si es aplicable) Le nom de la personne qui signe cette autorisation si ce n'est pas le patient