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**

Patient Name:_____ _____ _____ DOB: _____

CCHC ADULT PATIENT MEDICAL HISTORY (18+ Years)

HISTORY

Have you been seen by another physician? □ No □ Yes Name of physician: _____

Medications: _____

Drug / Medication Allergies: □ No □ Yes _____

Other Allergies: _____

	Self	Family History (Mother, Father, Brother, or Sister)		Self	Family History (Mother, Father, Brother, or Sister)
Alcohol or Drug Addiction	□	□	Hip problems	□	□
Anemia	□	□	Kidney Disease	□	□
Bleeding problems	□	□	Lung disease(COPD/TB, etc)	□	□
Arthritis	□	□	Melanoma / Skin Cancer	□	□
Asthma	□	□	Migraines	□	□
Bleeding Disorder	□	□	Rheumatic Heart Disease/ Fever	□	□
Blood clot in leg or lung	□	□	Scoliosis	□	□
Cancer Type _____	□	□	Sexually Transmitted Infection	□	□
Cystic Fibrosis	□	□	Sickle Cell Disease	□	□
Diabetes Type _____	□	□	Stomach problems	□	□
Epilepsy / Seizures	□	□	Stroke / Heart Disease	□	□
Heart Disease / Attack	□	□	Thyroid ConditionType _____	□	□
Hepatitis: Type _____	□	□	Ulcer	□	□
High Blood Pressure	□	□	Urinary problems / Pain	□	□
Developmental Disability: Autism Spectrum Disorder, Deaf, Blind, Intellectual Disability, Cerebral Palsy	□	□	**Mental Health Condition:** Depression, Bipolar, Schizophrenia, Anxiety, ADHD	□	□

HOSPITALIZATION, SURGERY, SERIOUS INJURY

EXAM / TEST **Where / Year**

Colon Screening: _____

Type: □ Fecal Occult Blood □ Flex Scope □ Colonoscopy

HgbA1c (diabetes) _____

Dental Exam _____

Eye Exam _____

MALE HEALTH

PSA/Rectal Exam-Where _____ Year __

Do you perform Self Testicular Exams □ Yes □ No

Have had any urology problems? □ Yes □ No

Testicular Problems? □ Yes □ No

FEMALE HEALTH

First menstrual period Age _____

Last menstrual period Date: _____/_____/_____

Menopause: Year _____

Miscarriages / Abortions: _____

Birth Control: □ None □ Pills □ Other:_____

Mammogram-Where_____ Year _____

Do you perform Self Breast Exams? □ Yes □ No

Pap Exam - Where _____ Year _____