

PATIENT FIRST NAME: _____ **MI:** _____ **LAST NAME** _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

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. Lee

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: _____

PATIENT NAME: _____ **DOB:** _____

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 Selfpay Sliding Fee

Name of Policy Holder: _____

Social Security Number of Policy Holder: _____ Date Of Birth: _____

Place of Employment: _____ Work Telephone Number: _____

Name of **Medical Insurance:** _____

Policy Number: _____ Member Number: _____ Effective Date: _____

Name of **Dental Insurance:** _____

Policy Number: _____ Member 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 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: _____ **Date:** _____

How did you hear about us? Newspaper Friend/Family Billboard Radio Other _____

PATIENT NAME: _____ **DOB:** _____

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:** _____

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

☒ Signature _____ **Date** _____

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

PATIENT NAME: _____ DOB: _____

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.

⇒ Patient Signature: _____ Date: _____

OR if patient is unable to sign Please Print:

_____	⇒ _____	_____
PRINT Representative / Parent / Guardian Name AND RELATIONSHIP	Signature Representative / Parent / Guardian	Date

If patient is less than 18 years of age – please complete this page

HEALTH HISTORY QUESTIONNAIRE

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

NAME (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:			
MARITAL STATUS:	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Previous Or Referring Doctor:				Date Of Last Physical Exam:		

PERSONAL HEALTH HISTORY						
CHILDHOOD ILLNESSES:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
IMMUNIZATIONS AND DATES:	<input type="checkbox"/> Influenza	<input type="checkbox"/> Td	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis B		
HEALTH SCREENINGS	<input type="checkbox"/> Colonoscopy When/Where:			<input type="checkbox"/> Chest XRay When/Where:		
	<input type="checkbox"/> Rectal Exam/Blood When/Where:			<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		How many drinks per week?			
Caffeine	Do you use caffeine?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind? <input type="checkbox"/> Chocolate <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda <input type="checkbox"/> Energy Drink <input type="checkbox"/> Tablet					
Tobacco	Do you use tobacco?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years		<input type="checkbox"/> Or year quit			
Drugs	Do you currently or have you ever used recreational or street drugs?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Type/Frequency _____					
Tattoos	Have you ever given yourself street drugs with a needle?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any tattoos?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diet	Diet <input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Low Salt / Low Sodium <input type="checkbox"/> Low Fat <input type="checkbox"/> Other _____					
Exercise	Exercise -Describe _____				<input type="checkbox"/> Yes	<input type="checkbox"/> No

NAME (Last, First, M.I.): _____ **DOB:** _____

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

NAME (Last, First, M.I.): _____ **DOB:** _____

FAMILY HISTORY

	Health Problems	Age	Deceased		Cause of Death		Health Problems	Age	Deceased		Cause of Death
Father		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Mother		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandmother Maternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandfather Maternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandmother Paternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandfather Paternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	

MEN ONLY

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

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____ Period every _____ days				
Last Pap Smear _____ Where? _____ Last mammogram _____ Last Bone Density screening _____				
Number of pregnancies _____ Number of live births _____ Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you pregnant or breastfeeding?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any blood in your urine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any problems with control of urination?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any hot flashes or sweating at night?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Vaginal Discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you sexually active? If yes with Male/Female/Both?- Please circle	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had more than one sexual partner in the past year?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No