

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

Social Security Number: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

Sex assigned at birth: Male Female

Gender Identity:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender Male / Female to Male
	<input type="checkbox"/> Transgender Female / Male to Female	<input type="checkbox"/> Other	<input type="checkbox"/> Choose not to disclose

Sexual Orientation:	<input type="checkbox"/> Lesbian or Gay	<input type="checkbox"/> Straight (not lesbian/gay)	<input type="checkbox"/> Bisexual
	<input type="checkbox"/> Something else	<input type="checkbox"/> Don't know	<input type="checkbox"/> 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: _____	<input type="checkbox"/> Dr. Royeen	<input type="checkbox"/> Dr. Curry	<input type="checkbox"/> Emily Eichelberger NP
YOUR DENTIST IS: _____	<input type="checkbox"/> Dr. Watson	<input type="checkbox"/> Dr. Johnson	
PREFERRED PHARMACY IS: _____ @ _____			

Ethnicity	<input type="checkbox"/> Not Hispanic / Not Latino	Race	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian
	<input type="checkbox"/> Hispanic / Latino		<input type="checkbox"/> Black/African American	<input type="checkbox"/> White
	<input type="checkbox"/> Unknown / Not Reported		<input type="checkbox"/> More than one race	<input type="checkbox"/> Native Hawaiian
			<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> 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: _____

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.

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: _____

	Family History (Mother, Father, Brother, or Sister)			Family History (Mother, Father, Brother, or Sister)	
	Self			Self	
Alcohol or Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hip problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease(COPD/TB, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma / Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart Disease/ Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot in leg or lung	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid ConditionType _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems / Pain	<input type="checkbox"/>	<input type="checkbox"/>

Developmental Disability: Autism Spectrum Disorder, Deaf, Blind, Intellectual Disability, Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Condition: Depression, Bipolar, Schizophrenia, Anxiety, ADHD	<input type="checkbox"/>	<input type="checkbox"/>
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HOSPITALIZATION, SURGERY, SERIOUS INJURY

EXAM / TEST	Where / Year
Colon Screening: _____	
Type: <input type="checkbox"/> Fecal Occult Blood <input type="checkbox"/> Flex Scope <input type="checkbox"/> Colonoscopy	
HgbA1c (diabetes) _____	
Dental Exam _____	
Eye Exam _____	

MALE HEALTH
PSA/Rectal Exam-Where _____ Year ____
Do you perform Self Testicular Exams <input type="checkbox"/> Yes <input type="checkbox"/> No
Have had any urology problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Testicular Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No

FEMALE HEALTH
First menstrual period Age _____
Last menstrual period Date: ____/____/____
Menopause: Year _____
Miscarriages / Abortions: _____
Birth Control: <input type="checkbox"/> None <input type="checkbox"/> Pills <input type="checkbox"/> Other: _____
Mammogram-Where _____ Year _____
Do you perform Self Breast Exams? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pap Exam - Where _____ Year _____

Patient Name: _____

DOB: _____

How hard is it for you to pay for the very basics like food, housing, medical care and heating?	<input type="checkbox"/> Very hard <input type="checkbox"/> Hard <input type="checkbox"/> Somewhat hard <input type="checkbox"/> Not very hard
What is the highest grade or level of school you have completed? _____	
Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled?	<input type="checkbox"/> Not at all <input type="checkbox"/> Only a little <input type="checkbox"/> To some extent <input type="checkbox"/> Rather much <input type="checkbox"/> Very much
Over the last 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Feeling down, depressed, or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every
*Office staff: depending on these answers you may have to complete the PHQ9	
How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? ___ days.	
On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? _____ minutes/day.	
How often do you have a drink containing alcohol?	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 4 or more times a week
How many standard drinks containing alcohol do you have on a typical day?	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 or more
How often do you have 6 or more drinks on 1 occasion?	<input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or Almost daily
Are you now? <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never married <input type="checkbox"/> Living with a partner	
In a typical week, how many times do you talk on the telephone with family, friends or neighbors? _____	
How often do you get together with friends or relatives? _____ time(s) a week	
How often do you attend church or religious services? _____ time(s) a year	
Do you belong to any clubs or organizations/ community groups? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within the last year have you been: <ul style="list-style-type: none"> • humiliated or emotionally abused in other ways by your partner or ex-partner? <input type="checkbox"/> Yes <input type="checkbox"/> No • afraid of your partner or ex-partner? <input type="checkbox"/> Yes <input type="checkbox"/> No • raped or forced to have any kind of sexual activity by your partner or ex-partner? <input type="checkbox"/> Yes <input type="checkbox"/> No • kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner? <input type="checkbox"/> Yes <input type="checkbox"/> No 	

**ARE THERE ANY OF THESE ITEMS YOU WANT HELP WITH? Yes No