Proudly Serving Four (4) Locations:

Comprehensive Health Care, Paoli 812.723.3944 (F) 812.723.7989
Crawford Co Family Health, Marengo 812.365.3221 (F) 812.365.9502
Patoka Family Health, English 812.338.2924 (F) 812.338.3706
Valley Health, West Baden 812.723.7125 (F) 812.936.2599

**Patient:** _____
Last Name First Name Middle Initial Social Security #

**Mailing Address** _____
**City:** _____ **State:** _____ **Zip:** _____ **Language:** ☐ English ☐ Spanish ☐ Other
**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Gender:** ☐ Male ☐ Female ☐ Transgender/Male to Female ☐ Transgender/ Female to Male ☐ Other
**Age:** _____ **DOB:** _____ **Email:** _____
*(Access Health Record 24 hrs. a day, 7 Days a Week)*

**Check One:** ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

**Race:** ☐ White (Non Hispanic or Latino) ☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian/Alaska Native
☐ Black/African American (Non Hispanic or Latino) ☐ Asian ☐ More than one race ☐ Unreported/Refused to Report

**Ethnicity** ☐ Non-Hispanic or Latino ☐ Hispanic/Latino
**Patient Employed By:** _____ **Occupation:** _____

**Billing Address:** _____ **Phone Number:** _____

**Do you have Medical Insurance?** ☐ Yes ☐ No **Insurance Company:** _____

**Person Insured:** _____ **ID #:** _____ **Group #:** _____ **SSN:** _____

**Birthdate:** _____

**Secondary Insurance?** ☐ Yes ☐ No **Insurance Company:** _____

**Person Insured:** _____ **ID #:** _____ **Group #:** _____ **SSN:** _____

**Birthdate:** _____

***If under 18 please list both biological Parents ***

**Mother:** _____ **Phone Number:** _____

**Father:** _____ **Phone Number:** _____

**IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?**

_____
Name Relationship Phone Number

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to SICHC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission.

_____
Signature of Insured/Guardian Date

## MEDICARE AUTHORIZATION

I request that payment of authorized benefits be made either to me or on my behalf to SICHC for any services furnished to me by my physician/nurse practitioner. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to the related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician/nurse practitioner agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
Signature of Insured/Guardian Date

**Patient Name:** _____ **DOB:** _____

**Social History/Income Assistance**

*The following questions may seem difficult to answer, but are important for us to know, so we can properly screen all our patients for their health care needs. Additionally, we have many programs to provide financial assistance and appreciate your answers to the below questions.*

Are you a seasonal worker? ☐ Yes ☐ No
Are you a migrant worker? ☐ Yes ☐ No
Are you a Veteran? ☐ Yes ☐ No
Are you homeless? ☐ Yes ☐ No
Do you live in public housing? ☐ Yes ☐ No (Housing provided for people with low income)
Household Size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more
Household Income ☐ $0 - $20,000 ☐ $20,001 - $35,000 ☐ $35,001 – $45,000
☐ $45,001 – $60,000 ☐ $60,001 & Over ☐ Decline to Answer
Does your insurance pay for prescriptions? ☐ Yes ☐ No
What is your sexual orientation? ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Do not know

**Past Medical History: Have you ever been diagnosed with any of the following** **Please Check Box**

| | | | | | |
|---|---|---|---|---|---|
| ☐ **Alcohol Addiction** | ☐ **Drug Addiction** | ☐ **Asthma** | ☐ **Bleeding/Clotting Tendencies** | ☐ **Cancer Type:** _____ | ☐ **Chronic Pain Location:** _____ |
| ☐ **Birth Defect** | | ☐ **COPD/ Emphysema** | ☐ **Depression** | ☐ **Diabetes Diagnosed** _____ **A1C** _____ | ☐ **Acid Reflux** |
| ☐ **Genital/Bladder Disease** | | ☐ **Heart Attack** | ☐ **Heart Disease** | ☐ **High Blood Pressure** | ☐ **Liver Disease** |
| ☐ **Mononucleosis** | | ☐ **Neurologic Disease** | ☐ **Renal/Kidney Disease** | ☐ **Rheumatic Fever** | ☐ **Sleeping Disorder** |
| | | ☐ **Seizures** | ☐ **Stomach Ulcers** | ☐ **Tuberculosis** | |

**Medication:**

****Please Include all medications, including over the counter and supplements.**
*****IF YOU NEED MORE ROOM, PLEASE USE THE BACK OF THIS PAPER*****

**Name:** _____ **Dose:** _____ **Frequency:** _____
**Name:** _____ **Dose:** _____ **Frequency:** _____
**Name:** _____ **Dose:** _____ **Frequency:** _____
**Name:** _____ **Dose:** _____ **Frequency:** _____
**Name:** _____ **Dose:** _____ **Frequency:** _____
**Name:** _____ **Dose:** _____ **Frequency:** _____
**Name:** _____ **Dose:** _____ **Frequency:** _____

**Hospital/Surgical History:**

**Explain:** _____
**Date:** _____ **Facility:** _____
**Explain:** _____
**Date:** _____ **Facility:** _____
**Explain:** _____
**Date:** _____ **Facility:** _____
**Explain:** _____
**Date:** _____ **Facility:** _____

Patient Name: _____ DOB: _____

**Allergies:**

1) Medication: _____ Reaction: _____
2) Medication: _____ Reaction: _____
3) Medication: _____ Reaction: _____
4) Environmental: _____
5) Food: _____

**Habits:**

Do you exercise? ☐ Yes ☐ No Type/Frequency: _____

Do you smoke? ☐ Yes ☐ No How Much/Often: _____ ☐Former Smoker ☐ Never Smoker

Drink alcohol? ☐ Yes ☐ No How Much/Often: _____ Quit ☐ Yes ☐ No Date: _____

Drugs Use? ☐ Yes ☐ No How Much/Often: _____ Quit ☐ Yes ☐ No Date: _____

Caffeine Use? ☐ Yes ☐ No Cups per day: _____

**Date of last Immunization?**

Influenza: Date: _____
Pneumovax: Date: _____
Tetanus: Date: _____
Shingles Date: _____
COVID-19 Date(s):_____

**Have you traveled to other countries within the last year?** ☐ Yes ☐ No

Where: _____ Date: _____
Where: _____ Date: _____
Where: _____ Date: _____

**Females Only:**

When was your last menstrual period? _____
Number of Pregnancies: _____
Number of Births: _____
Last pap/GYN exam approx. Date: _____ History of Abnormal? ☐ Yes ☐ No
Preformed by: _____
Age of Menopause: _____ N/A
Last mammogram: _____ N/A
Hysterectomy ☐ Yes ☐ No Date _____ Reason _____

**Health Maintenance**

Last Colonoscopy: _____ ☐ Normal ☐ Abnormal
Colonoscopy Preformed by: _____
Last DEXA Scan: _____
Last Dilated Eye Exam: _____

**Do you have Advanced Directives?**

Living Will ☐ Yes ☐ No
Durable Power of Attorney ☐ Yes ☐ No
Would you like information on creating a living will? ☐ Yes ☐ No

**Patient Name:** _____ **DOB:** _____

**Family History: Please check box and circle relationship to you**

**PFG: Paternal Grandfather PGM: Paternal Grandmother M: Mother F: Father**
**MGF: maternal Grandfather MGM: maternal Grandmother B: Brother S: Sister**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Anxiety | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Arthritis | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Asthma | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Cancer Type: _____ | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Coronary Artery Disease | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Depression | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Diabetes | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Gastric Rflux | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Heart Attack | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| High Cholesterol | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Hypertension/High Blood Pressure | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Migraines | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Obesity | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Stomach Ulcers | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Stroke | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |
| Other: _____ | ☐ | PGF | PGM | MGF | MGM | M | F | B | S |

**Please list any other health care providers (i.e., Dentist, GYN, Cardio, etc.) Be sure to include the provider's name and location.**

_____

_____

_____

_____

_____

**Other Pertinent Medical Information you would like to share with us?**

_____

_____

_____

_____

_____

**X** _____ _____
**Patient Signature** **Date**

**X** _____ _____
**Parental/Guardian Signature** **Date**

**X** _____ _____
**Signature of Reviewing Provider** **Date**