

# CHEROKEE REGIONAL CLINICS PATIENT INFORMATION

(Please complete and return to receptionist)  
PATIENT DEMOGRAPHICS

Today's Date: \_\_\_\_\_

|  |  |   |  |             |  |
|--|--|---|--|-------------|--|
| Name:  |  | Birth Date:   |  | Age:        |  |
| Address:   |  | City:   |  | State: Zip: |  |
| Phone: ( )   |  | Cell: ( )   |  | Work: ( )   |  |
| Soc. Security #:   |  | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female  |  |             |  |
| Marital Status: M S W D  |  | Spouse's Name:  |  |             |  |
| Maiden Name:   |  | Previous Married Names:   |  |             |  |
| Patient Employer:  |  |   |  |             |  |
| Address:   |  | City:   |  | State: Zip: |  |
| Phone: ( )   |  | Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Empl. <input type="checkbox"/> Retired |  |             |  |
| ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino                         |  |   |  |             |  |
| Preferred Language:  |  |   |  |             |  |
| RACE: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native |  |   |  |             |  |
| <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other:       |  |   |  |             |  |

## MALE HEAD OF HOUSEHOLD/HEAD OF HOUSEHOLD

|                    |  |               |  |             |  |
|--------------------|--|---------------|--|-------------|--|
| Name:              |  | Relationship: |  | Birth Date: |  |
| Phone: ( )         |  | Cell: ( )     |  |             |  |
| Employer:          |  |               |  |             |  |
| Employer Address:  |  | City:         |  | State: Zip: |  |
| Social Security #: |  |               |  |             |  |

## EMERGENCY CONTACT INFORMATION

|                                     |  |                     |  |
|-------------------------------------|--|---------------------|--|
| Name of nearest friend or relative: |  | Relationship:       |  |
| Home Phone: ( )                     |  | Cell: ( ) Work: ( ) |  |

## INSURANCE INFORMATION

- Please produce your card for a copy to be taken

|                              |  |                         |  |
|------------------------------|--|-------------------------|--|
| Primary Insurance Company:   |  | Effective Date:         |  |
| Policy Holder Name:          |  | Primary Care Physician: |  |
| Policy Holder Address:       |  | Birth Date: Policy #:   |  |
| Secondary Insurance Company: |  | Effective Date:         |  |
| Policy Holder:               |  | Primary Care Physician: |  |
| Policy Holder Address:       |  | Birth Date: Policy #:   |  |
| Medicare #:                  |  |                         |  |
| Title XIX #:                 |  | Medipass Physician:     |  |

## FAMILY INFORMATION

| Immediate Family Members: | Previous Physicians (last 5 years): |
|---------------------------|-------------------------------------|
| 1)                        | 1)                                  |
| 2)                        | 2)                                  |
| 3)                        | 3)                                  |
| 4)                        | 4)                                  |
| 5)                        | 5)                                  |

# CHEROKEE REGIONAL CLINICS CHEROKEE REGIONAL MEDICAL CENTER

## CONSENT FOR TREATMENT

I hereby authorize Cherokee Regional Clinics and Cherokee Regional Medical Center to administer such treatment as is necessary.

## HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Officer at Cherokee Regional Medical Center.

By signing this form, you acknowledge that a copy of our current Notice of Privacy Practices has been made available to you.

Patient or Patient Representative: \_\_\_\_\_

Date: \_\_\_\_\_

## STATEMENT OF ACCURACY

I confirm that all the information provided on this document is true and accurate.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physicians or the organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signature of Patient: \_\_\_\_\_

Signed for Patient by: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Witness: \_\_\_\_\_

Reason Patient cannot sign: \_\_\_\_\_

# CHEROKEE REGIONAL CLINICS

## Teen/Child/Infant History Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications (include vitamins): \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Past Major Injuries (broken bones, concussions, etc.): \_\_\_\_\_

Past Hospitalizations: \_\_\_\_\_

### FAMILY HISTORY

|           | Alive | Deceased | Current age or age at death | Cause of Death (if applicable) | Has any blood relative ever had: | Yes | No | Relationship | Age of Onset |
|-----------|-------|----------|-----------------------------|--------------------------------|----------------------------------|-----|----|--------------|--------------|
| Mother    |       |          |                             |                                | Cancer                           |     |    |              |              |
| Father    |       |          |                             |                                | Glaucoma                         |     |    |              |              |
| Siblings: |       |          |                             |                                | Tuberculosis                     |     |    |              |              |
| 1.        |       |          |                             |                                | Diabetes                         |     |    |              |              |
| 2.        |       |          |                             |                                | Heart trouble                    |     |    |              |              |
| 3.        |       |          |                             |                                | High blood pressure              |     |    |              |              |
| 4.        |       |          |                             |                                | Stroke                           |     |    |              |              |
|           |       |          |                             |                                | Epilepsy                         |     |    |              |              |
|           |       |          |                             |                                | Emotional problems               |     |    |              |              |
|           |       |          |                             |                                | Birth defects                    |     |    |              |              |
|           |       |          |                             |                                | Suicide                          |     |    |              |              |
|           |       |          |                             |                                | Other serious disease            |     |    |              |              |

### HOME ENVIRONMENT

Others who live in the same household: \_\_\_\_\_

Does anyone smoke in the home? (circle one): Yes No

Pets in the home? (circle one): Yes No If yes, what kind? \_\_\_\_\_