CHEROKEE REGIONAL CLINICS
PATIENT INFORMATION

(Please complete and return to receptionist) **Today's Date: _____**

PATIENT DEMOGRAPHICS

Name:	Birth Date:	Age:
Address:	City: State:	Zip:
Phone: ( )	Cell: ( )	Work: ( )
Soc. Security #:	Sex: ☐ Male ☐ Female	
Marital Status: M S W D	Spouse's Name:	
Maiden Name:	Previous Married Names:	
Patient Employer:		
Address:	City: State:	Zip:
Phone: ( )	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Empl.	

ETHNICITY: ☐ Hispanic or Latino ☐ Non Hispanic or Latino
Preferred Language:
RACE: ☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ 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
Cherokee, Holstein, Marcus

ADULT HEALTH HISTORY

Today's Date:_____

Name:_____ Cell #:_____ Date of Birth:_____

Marital Status:_____(Spouses Name)_____

Occupation:_____Employer:_____

Ethnicity:
☐ Hispanic or Latino ☐ Non Hispanic or Latino
Race:
☐ White ☐ Black ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian or Pacific Islander
Preferred Language: _____

PRESENT HEALTH CONCERNS: _____

_____

PAST MEDICAL CONDITIONS: _____

_____

_____

Allergies: _____

Preferred Pharmacy: _____

Current Medications with dose: _____

_____

_____

Surgeries & Hospitalizations: _____

_____

Immunizations: Did you have all your childhood immunizations? ☐Yes ☐No
Date of last Tetanus:_____
Blood Transfusions: ☐Yes (Year: ____) ☐No

Have you used street drugs? ☐Yes ☐No

Have you used IV drugs? ☐Yes ☐No

Do you drink alcohol? ☐ Yes ☐No ☐ Less than once a month

If Yes – ☐Daily ☐Occasionally When you drink, how many drinks do you typically have: ___

Do you drink caffeine ☐No ☐ Yes – ☐Daily ☐Occasionally

Do you smoke and if so, how much: ☐Current every day smoker ☐Current someday smoker

☐Former smoker ☐ Never Smoked ☐Smoker current status unknown ☐ unknown if ever smoked

OVER PLEASE

FAMILY HISTORY

Patient Name: **Date of Birth:**

	Year of Birth	Cause of Death (if applicable)	Age at Death
List names of Relatives Below			
Mother:			
Father:			
Siblings:			
1.			
2.			
3.			
4.			
Children:			
1.			
2.			
3.			
4.			

Has any blood relative ever had	Yes	No	Relationship/Age of Onset
Cancer			
Glaucoma			
Tuberculosis			
Diabetes			
Heart problems			
High blood pressure			
Stroke			
Emotional problems			
Birth defects			
Suicide			
Epilepsy			
Other serious disease			

Updated Form: 12/10, 8/11, 10/11 CRC82511B