Cherokee Regional Clinics

PATIENT INFORMATION UPDATE

Date: _____

Print Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Spouse's Name: _____

Phone Number - Home: _____ Cell: _____

Employer: _____

Work Number: _____

Health Insurance Plan: _____

(Please present your insurance card to the front desk.)

Policy Holder: _____

Policy Holder Date of Birth: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic

Preferred Language: _____

Race: ☐ White ☐ Black ☐Asian ☐ Native Hawaiian/Pacific Islander
☐ American Indian or Alaskan Native ☐ Other:_____

Other members of household:

1) _____
2) _____
3) _____
4) _____
5) _____

Other physicians you've seen:
(in case we need to request records)

1) _____
2) _____
3) _____
4) _____
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: _____

Patient Name:	**Date of Birth:**
PRESENT HEALTH CONCERNS:	
PAST MEDICAL CONDITIONS:	
Allergies:	
Preferred Pharmacy:	
Current Medications with dose:	
Surgeries & Hospitalizations:	
Date of last Tetanus:	

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

FAMILY HISTORY

List names of Relatives Below	Year of birth	Cause of Death (if applicable)	Age at Death
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:			