Community Medical Clinic
Astoria
A Department of Culbertson Memorial Hospital

135 West Broadway
Astoria, IL 61501
Phone: 309-329-2926
Fax: 309-329-2656
cmhospital.com/culbertsonclinics

Thank you for choosing Community Medical Clinic for your Healthcare needs. We always strive to provide quality, compassionate care to the communities we serve.

PLEASE ARRIVE TO THE CLINIC 30 MINUTES EARLY FOR YOUR APPOINTMENT

Please bring the following with you to your appointment:

- ☐ Driver's License or Photo Id
- ☐ All Current Insurance Cards
- ☐ All Current Medications (In The Bottles)
- ☐ FOR MINORS: Consent to Treat
- ☐ New Patient Packet (Please complete and sign all forms before appointment)
  - Demographics
  - Clinical History
  - Patient Authorization to Permit Use and Disclosure of Health Information
  - No Show Policy

If you cannot make it to your scheduled appointment, please call in advance to cancel or reschedule.

(309) 329-2926

Thank you!

Community Medical Clinic Provider and Staff

Cindy Chaffin, APN-C

Amber Rector, PA-C

Culbertson Clinics
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PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

LAST NAME:	**FIRST:**	**M.I.:**	**GENDER:**
PREFERRED NAME:	**MAIDEN NAME:**		**DOB:**
SSN:	**EMAIL:**		
ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**COUNTY:**
PRIMARY PHONE:	**SECONDARY PHONE:**		
RELIGION:	**RACE:**		

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ REFUSED TO ANSWER

PRIMARY LANGUAGE SPOKEN: **INTEPRETER NEEDED:** ☐ YES ☐ NO

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

TOBACCO USER: ☐ YES (EVERY DAY) ☐ YES (SOME DAYS) ☐ NEVER ☐ FORMER

IF YES, TYPE: ☐ SMOKELESS TOBACCO ☐ SMOKABLE TOBACCO

CONTACT/BILLING INFORMATION

SPOUSE: ☐ N/A			DOB:
EMERGENCY CONTACT:			DOB:
PHONE:	RELATIONSHIP TO PATIENT:		
FATHER: IF PATIENT IS MINOR CHILD			PHONE:
MOTHER: IF PATIENT IS MINOR CHILD			PHONE:

PATIENT EMPLOYER: ☐ N/A

OCCUPATION:	STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ NOT EMPLOYED		
PHONE:	ADDRESS:		

DO YOU HAVE INSURANCE: ☐ YES (A COPY OF YOUR INSURANCE CARD IS REQUIRED) ☐ NO (PRIVATE PAY)

INSURANCE SUBSCRIBER: (THE PERSON WHO ENROLLED FOR THE INSURANCE) ☐ **CONTACT INFO SAME AS PATIENT**

LAST NAME:	FIRST NAME:		M.I.:
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PRIMARY PHONE:	SECONDARY PHONE:		

RESPONSIBLE PARTY: (THE PERSON WHO IS RESPONSIBLE FOR THE BALANCE) ☐ **SAME AS INSURANCE SUBSCRIBER**

LAST NAME:	FIRST NAME:		M.I.:
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PRIMARY PHONE:	SECONDARY PHONE:		

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NAME:_____

CLINICAL HISTORY

PREVENTIVE HEALTH

ADULTS When was your last vaccine for:		**PEDIATRIC**
TETANUS:	SHINGLES:	IMMUNIZATIONS UP TO DATE: ☐ YES ☐ NO
FLU:	PNEUMONIA:	WHERE RECEIVED:
HEPATITIS:	COLONSCOPY:	*PLEASE PROVIDE A COPY OF YOUR CHILD'S COMPLETE IMMUNIZATION RECORD*
MAMMOGRAM: (Female Only)	PAP SMEAR: (Female Only)	

	MEDICAL HISTORY	FAMILY HISTORY
ANXIETY/DEPRESSION	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
ANEMIA	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
ARTHRITIS	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
ASTHMA	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
CANCER	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
CATARACTS/GLAUCOMA	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
COPD	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
DIABETES	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
HEART DISEASE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
HIGH BLOOD PRESSURE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
HIGH CHOLESTEROL	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
KIDNEY DISEASE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
STROKE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
THYROID DISEASE	☐ YES ☐ NO	☐ YES ☐ NO RELATIONSHIP:
OTHER:		OTHER:

ALLERGIES

☐ **No Known Allergies**

NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:

SURGICAL HISTORY

SURGERY:	DATE:	SURGERY:	DATE:
SURGERY:	DATE:	SURGERY:	DATE:
SURGERY:	DATE:	SURGERY:	DATE:
SURGERY:	DATE:	SURGERY:	DATE:

RECENT HOSPITALIZATION/ER VISITS

REASON:	DATE:	REASON:	DATE:
REASON:	DATE:	REASON:	DATE:

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NAME:_____

CLINICAL HISTORY

SOCIAL HISTORY

TOBACCO: ☐ NON-SMOKER ☐ FORMER SMOKER When Did You Quit: _____

☐ CURRENT SMOKER
HOW MUCH: ____ PACK(S) PER DAY

WHAT TYPE: ☐ CIGARETTES ☐ SMOKELESS TOBACCO ☐ ELECTRONIC CIGARETTE

ALCOHOL: ☐ NON-DRINKER ☐ FORMER DRINKER When Did You Quit: _____

☐ CURRENT DRINKER
HOW MUCH: ☐ 1-2 DRINKS DAILY ☐ 3-4 DRINKS DAILY ☐ MORE THAN 5 DRINKS DAILY ☐ ONCE A WEEK

☐ OCCASIONALLY ☐ SOCIALLY

WHAT TYPE: ☐ WINE ☐ BEER ☐ SPIRITS

CAFFEINE: ☐ NO

☐ YES
HOW MUCH: ☐ 1-2 CUPS DAILY ☐ 3-4 CUPS DAILY ☐ 1-2 CUPS WEEKLY ☐ 3-4 CUPS WEEKLY

☐ MORE THAN 5 DAILY ☐ MORE THAN 5 WEEKLY

PRESCRIPTION DRUG ABUSE: ☐ NO ☐ YES _____

ILLICIT DRUG ABUSE: ☐ NO ☐ YES _____

EXERCISE:
☐ NONE ☐ WALKING ☐ RUNNING ☐ WEIGHT LIFTING ☐ YOGA

☐ ZUMBA ☐ PILATES ☐ BIKING ☐ SWIMMING ☐ GARDENING

☐ OTHER: _____

CURRENT MEDICATIONS

PLEASE LIST BELOW, ALL MEDICATIONS, INCLUDING DOSAGE AND DIRECTIONS.

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SDCMH PATIENT AUTHORIZATION

To Permit Use and Disclosure of Health Information

Re: _____ _____/_____/_____
Patient Name/MR ID Number Date of Birth

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize SARAH D. CULBERTSON MEMORIAL HOSPITAL AND its designees to disclose PHI to the following individuals:

Name of Individual	Relationship to Patient	Phone Number

Person or class of persons to whom disclosure would be made

The purpose of the use or disclosure is: At the request of the above named individual.

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it (or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy). If I revoke this authorization, I must do so in writing. The procedure for revoking this authorization is to send a written request to revoke this authorization to CMH, to the attention of the Privacy Officer. Include the effective date and if this revocation involves all previously named individuals.

I understand that I may refuse to sign this Authorization. I also understand that Sarah D. Culbertson Memorial Hospital will not condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

This authorization expires automatically upon revocation by me or upon my death.

I have read and understand the information in this authorization form.

Signature of Patient:	
Please print name:	Date:

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CINDY CHAFFIN, APN-C **AMBER RECTOR, PA-C**

NO SHOW POLICY

A "No-Show" is defined as an appointment that was previously scheduled; however, the patient did NOT show up or notify the clinic of their absence.

"No-Show" appointments are recorded and counted within a fiscal year and the following actions will be taken:

1. **1st Offense**: A letter will be mailed stating your appointment was missed, requesting you to notify our office, in advance, to cancel any future appointments that can't be kept.

2. **2nd Offense**: A letter will be mailed stating your appointment was missed, as well as informing you that a few will be assessed on the next offense.

3. **3rd Offense**: A letter will be mailed stating your appointment was missed, as well as informing you that a **$40.00 fee has been charged to your account.** Current collection policies will apply.

4. **4th Offense**: A letter will be mailed stating **you are TERMINATED** from all Culbertson Memorial Hospital associated clinics.

By signing this notice, you understand the policy of "No-Show" appointments at Community Medical Clinic.

_____ _____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

SIGNATURE OF PATIENT OR PERSON REPRESENTATIVE

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CANCELLATION/RESCHEDULE POLICY

A "cancellation/reschedule" is defined as an appointment that was previously scheduled; however, the patient did NOT provide 24 hour notice to the clinic of their absence.

"Cancellations" are recorded and counted within a calendar year as follows:

5. 3 Cancellations with less than 24 hour notice in one calendar month, occurring twice in a calendar year.
6. 10 Cancellations with less than 24 hour notice in a calendar year

The following actions will be taken:

1. **After 3 cancellations within a month**: A letter will be mailed stating the dates of cancelled appointments with a request to notify the office of necessary cancellations with greater than 24 hour notice in the future.

2. **After the second month of 3 cancellations**: A letter will be mailed stating the months and dates of cancelled appointments and notification of **TERMINATION** from all Culbertson Memorial Hospital associated clinics.

3. **After 10 cancellations within 1 calendar year**: A letter will be mailed stating the months and dates of cancelled appointments and notification of **TERMINATION** from all Culbertson Memorial Hospital associated clinics.

By signing this notice, you understand the policy of "Cancellations" at Community Medical Clinic.

_____ _____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE