



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.

(217) 322-5236

Thank you!

Community Medical Clinic Provider and Staff



**Cindy Chaffin,
APN-C**

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: <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> REFUSED TO ANSWER					
PRIMARY LANGUAGE SPOKEN:			INTEPRETER NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO		
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPERATED <input type="checkbox"/> WIDOWED					
TOBACCO USER: <input type="checkbox"/> YES (EVERY DAY) <input type="checkbox"/> YES (SOME DAYS) <input type="checkbox"/> NEVER <input type="checkbox"/> FORMER					
IF YES, TYPE: <input type="checkbox"/> SMOKELESS TOBACCO <input type="checkbox"/> SMOKABLE TOBACCO					
CONTACT/BILLING INFORMATION					
SPOUSE: <input type="checkbox"/> 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: <input type="checkbox"/> N/A					
OCCUPATION:		STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> NOT EMPLOYED			
PHONE:		ADDRESS:			
DO YOU HAVE INSURANCE: <input type="checkbox"/> YES (A COPY OF YOUR INSURANCE CARD IS REQUIRED) <input type="checkbox"/> NO (PRIVATE PAY)					
INSURANCE SUBSCRIBER: (THE PERSON WHO ENROLLED FOR THE INSURANCE)				<input type="checkbox"/> 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) <input type="checkbox"/> SAME AS INSURANCE SUBSCRIBER					
LAST NAME:		FIRST NAME:		M.I.:	
ADDRESS:					
CITY:		STATE:	ZIP:	COUNTY:	
PRIMARY PHONE:			SECONDARY PHONE:		

NAME: _____

CLINICAL HISTORY

PREVENTIVE HEALTH			
ADULTS When was your last vaccine for:		PEDIATRIC	
TETANUS:	SHINGLES:	IMMUNIZATIONS UP TO DATE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
FLU:	PNEUMONIA:	WHERE RECEIVED:	
HEPATITIS:	COLONOSCOPY:	<i>PLEASE PROVIDE A COPY OF YOUR CHILD'S COMPLETE IMMUNIZATION RECORD</i>	
MAMMOGRAM: (Female Only)	PAP SMEAR: (Female Only)		
MEDICAL HISTORY		FAMILY HISTORY	
ANXIETY/DEPRESSION	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
ANEMIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
ARTHRITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
CATARACTS/GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
COPD	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
HEART DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
HIGH CHOLESTEROL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
KIDNEY DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
STROKE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
THYROID DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP:
OTHER:		OTHER:	
ALLERGIES <input type="checkbox"/> 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:

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.

CULBERTSON CLINICS 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 CULBERTSON CLINICS 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. The procedure for revoking this authorization is to send a written request to Culbertson Clinics, Attn: Clinic Director, 238 South Congress Street, Rushville, IL 62681. The request must include my full legal name, date of birth, the effective date of the revocation, and the names to be revoked.

I understand that I may refuse to sign this Authorization. I also understand that Culbertson Clinics 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:

Revised 1/15/26: MLS

Patient Appointment Cancellation, No-Show, and Late Arrival Agreement

Our goal is to provide excellent care for each patient in a timely manner. Keeping scheduled appointments allows our Medical Providers to care for all patients efficiently and ensures appointment availability for those in need of medical services.

No-Show: A patient who fails to arrive for a scheduled appointment.

Same-Day Cancellation: A patient who cancels an appointment less than 24 hours before the scheduled appointment time.

Late Arrival: A patient who arrives 15 minutes or more after the scheduled appointment time.

Appointment Cancellation Policy

If it is necessary to cancel an appointment, patients are required to notify the registration department at least 24 hours prior to the scheduled appointment time. Timely notification allows the Schuyler County Hospital District and Schuyler County Hospital District Health Centers to offer the appointment to another patient who may need care.

Late Arrival Policy

Patients who arrive more than fifteen (15) minutes late may not be able to be seen by the provider on the same day. If the provider is unable to see the patient due to late arrival, the appointment may be rescheduled for a future date. In these cases, the late arrival will be documented as a no-show.

Monitoring No-Shows and Late Cancellations

The Schuyler County Hospital District and Schuyler County Hospital District Health Centers monitor and manage appointment no-shows and late cancellations in order to maintain access to care for all patients.

- Three (3) documented no-shows or same-day cancellations within a 12-month period will result in a written warning letter notifying the patient of possible revocation of scheduling privileges.
- Four (4) documented no-shows or same-day cancellations within a 12-month period will result in revocation of scheduling privileges. Patients will then only be eligible to receive care on a walk-in basis, subject to provider availability.

Patient Acknowledgement

By signing below, I acknowledge I have received, read, and understand the Schuyler County Hospital District and Schuyler County Hospital District Health Center's Appointment Cancellation, No-Show, and Late Arrival Policy. I understand that failure to comply with this policy may result in limitations on my ability to schedule future appointments.

Patient Name (Print): _____

Patient or Patient Representative Signature: _____

Date: _____