



**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**

## PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION				
LAST NAME:		FIRST:		M.I.:
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			
<b>ADULTS</b> When was your last vaccine for:		<b>PEDIATRIC</b>	
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:
CATERACTS/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 <span style="float: right;"><input type="checkbox"/> No Known Allergies</span>			
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.



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

### 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:

**CINDY CHAFFIN, APN-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. **1<sup>st</sup> 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. **2<sup>nd</sup> Offense:** A letter will be mailed stating your appointment was missed, as well as informing you that a fee will be assessed on the next offense.
3. **3<sup>rd</sup> 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. **4<sup>th</sup> 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.

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NAME OF PATIENT OR PERSONAL REPRESENTATIVE

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DATE

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SIGNATURE OF PATIENT OR PERSON REPRESENTATIVE

**CINDY CHAFFIN, APN-C**

**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