CHILD

Campbell County Memorial Hospital Clinics

Preferred Pharmacy:

Patient Information

Last Name: _____ First Name: _____ MI: _____ Sex: M/F

SSN: _____ - _____ - _____ Date of Birth: _____ Home Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

PARENT OR LEGAL GUARDIAN INFORMATION

Mother's Name	Mailing Address	City	State Zip
Mother's Social Security Number	Mother's Home/Cell Phone Number	Mother's Employer	Mother's Work #
Father's Name	Mailing Address	City	State Zip
Father's Social Security Number	Father's Home/Cell Phone Number	Father's Employer	Father's Work#

Responsible Party

Responsible Party Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____ - _____ - _____ Relationship to patient _____

Responsible Party Employer: _____ Phone Number: _____

Primary Insurance Information

Name of Insurance: _____ Phone Number: _____

Insurance Address: _____

Policy Holders Name: _____ D.O.B. _____ Relationship to patient _____

Policy #: _____ Group # _____ Effective Date: _____

Policy Holders SSN: _____ - _____ - _____

Secondary Insurance Information

Name of Insurance: _____ Phone Number: _____

Insurance Address: _____

Policy Holders Name: _____ Relationship to patient _____

Policy #: _____ Group # _____ Effective Date: _____

Is this injury work related? Yes___ No___ Worker's Compensation Claim Number _____

Financial Agreement and Authorization (please read and sign)

I understand and agree that I am assuming responsibility to pay ALL fees and charges for the treatment of the person names above (regardless of insurance), unless I inform you otherwise in writing. I agree to pay all charges for me and members of my family when services are rendered. In the event legal action becomes necessary to collect any unpaid charge. I agree to pay costs of collection, including attorney's fees. It is agreed that payments will not be delayed or withheld because of my insurance coverage or the pendency of claims for the collection thereof, and all proceeds of insurance are assigned to this office. Unless otherwise paid, but without the office assuming any responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

I understand that all charges are payable at the time of service regardless of insurance and any charges allowed pending insurance is at the sole discretion of Campbell County Memorial Hospital Clinics.

By my signature below, I acknowledge that Campbell County Memorial Hospital Clinics has made available its "Notice of Privacy Practices" for me to review and that I may request a copy if I so desire.

CONSENT/RELEASE: The undersigned herby authorizes this clinic to release appropriate information to the patient's referring doctor and/or health and/or government agency and/or insurance agency and/or professional consultant selected by the physician of this clinic. I certify that the information is true and correct to the best of my knowledge. I understand that I may be charged a fee for copying such records. I will notify this clinic of any changes in my health insurance status of the above information. This form gives permission for Campbell County Memorial Hospital Clinics to treat the above named patient.

Signature (Parent or guardian if a minor) _____ **Date** _____

RELEASE OF INFORMATION AUTHORIZATION

I, _____ _____ _____
Name Birthday SS #

hereby authorize and request the use and disclosure of all health information that pertains to me. I authorize **CCMH-Clinics** to make these disclosures of my health information to the following persons and elect not to provide a statement of purpose for the use of the disclosure to the following persons:

_____ Do not release information to anyone other than myself.

_____ Release my protected health information to the following people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that any information disclosed to this authorization may be re-disclosed to additional parties that are not subject to HIPAA and may no longer be protected by HIPAA.

I understand that this authorization will automatically expire one year from the date signed, but that I may revoke this authorization at any time by signing the revocation section of this form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

_____ _____
Signature Date

AUTHORIZATION FOR MESSAGES

I hereby authorize **CCMH-Clinics** to call my residence for the purpose of leaving messages regarding my health care. In case I am not available to receive the call, I also authorize **CCMH-Clinics** to communicate the call by:

- leaving a message with the person who answers the telephone call: or by
- leaving a message on my answering machine/voice mail.

I understand that the message will identify the call as coming from **CCMH-Clinics**

_____ _____
Signature Date

** ONLY COMPLETE THIS SECTION IF YOU WISH TO REVOKE AUTHORIZATION **

I revoke this authorization effective (date)_____

_____ _____
Signature Date

Campbell County Memorial Hospital Clinics

NAME:_____BIRTH DATE:_____ AGE:_____
REASON FOR VISIT:_____

Primary Care Physician: _____

Past Medical History: Do you have, or have you ever had any of the following:

	YES	DATE		YES	DATE
Anemia			Heart Disease		
Arthritis			Hepatitis		
Asthma			High Blood Pressure		
Bleeding Disorder			HIV/AIDS		
Cancer			Kidney Disease		
Colitis			Liver Problems		
Diabetes			Lung Problems		
Diverticulitis			Mental Illness		
Emphysema			Ovarian Cysts		
Epilepsy or Seizures			Prostate Problems		
Endometriosis			STDs		
Glaucoma			Stroke		
Gout			Stomach Ulcers		
Headaches			Tuberculosis TB		
Heart Attack			Thyroid Problems		

Please list any surgeries you have had (If more room is needed please write on back)

Surgery/Reason			Date				Date		

Please list all medications you are currently taking (If more room is needed please write on back)
Include all vitamins, minerals, herbals and Over the Counter Medications

Drug Name/Dose			Physician		Drug Name/Dose		Physician		

Are you allergic to latex? YES NO

Please list all allergies and reactions (If known).

Drug Name			Reaction		Drug Name/Dose		Reaction		

Family Medical History:
Has anyone in your family had:

	Yes	Family Member
Anemia		
Arthritis		
Cancer		
Colitis		
Diabetes		
Gout		
Heart Attack		
Heart Disease		

	Yes	Family Member
High Blood Pressure		
Kidney Disease		
Liver Disease		
Lung Disease		
Psychiatric Issues		
Stroke		
Tuberculosis		

Social History:
Please check all that apply

1. Do you smoke regularly? Yes No
   How many per day? Packs___ Each_____
   How long? _____ Years

2. Have you eer smoked in the past? Yes No

3. Have you ever used or do you use illicit drugs? Yes No

For Women Only:

1. Are you pregnant? Yes No

2. Are you trying to become pregnant? Yes No

4. Number of pregnancies (including miscarriages and abortions): _____

Number of Babies: Term_____ Preterm:_____ Miscarriages: _____

Pregnancy	Date of Birth	Birth Weight	Type of Delivery
First			
Second			
Third			
Fourth			
Fifth			

3. Date you began your last menstrual period _____

*******NOT PART OF PATIENT MEDICAL RECORD*******

NAME: _____ DATE: _____ BIRTH DATE: _____ AGE: _____

Please mark any current symptoms you may have.

CONSTITUTIONAL

Fever	YES	NO
Chills	YES	NO
Night Sweats	YES	NO
Fatigue	YES	NO
Unexplained Weight Loss	YES	NO

EYES

Change in vision	YES	NO
Eye pain / tenderness	YES	NO
Contacts or glasses	YES	NO
Discharge from eye	YES	NO

HEAD, EARS, NOSE & THROAT

Headache	YES	NO
Sinus Pain	YES	NO
Sore Throat	YES	NO
Ear Pain	YES	NO
Neck Stiffness	YES	NO
Oral Lesions	YES	NO

CARDIOVASCULAR

Fainting Spells	YES	NO
Painful Breathing on Exertion	YES	NO
Leg swelling	YES	NO
Chest Pain	YES	NO
Leg Pain while walking	YES	NO
Claudication (Blood Clots)	YES	NO
Irregular Heart Beats	YES	NO
Difficulty breathing lying down	YES	NO

RESPIRATORY

Shortness of breath	YES	NO
Cough	YES	NO
Wheezing	YES	NO
Coughing up blood	YES	NO
Painful Breathing	YES	NO
Chest congestion	YES	NO

GASTROINTESTINAL

Nausea	YES	NO
Heartburn	YES	NO
Difficulty Swallowing	YES	NO
Abdominal Pain	YES	NO
Black Stools	YES	NO
Vomiting	YES	NO
Diarrhea	YES	NO
Constipation	YES	NO

UTERINE / URINARY

Excessive urination	YES	NO
Excessive thirst	YES	NO
Hot Flashes	YES	NO

INTEGUMENTARY (SKIN)

Rash	YES	NO
New Skin Lesion	YES	NO
Changes to existing Lesion	YES	NO

GENITOURINARY

Painful urination	YES	NO
Blood in urine	YES	NO
Frequent urination at night	YES	NO
Incontinence	YES	NO
Difficulty emptying bladder	YES	NO
Heavy/Irregular bleeding	YES	NO
Impotence	YES	NO
Decreased Libido (Sex Drive)	YES	NO

NEUROLOGICAL

Tingling or Numbness	YES	NO
Seizures	YES	NO
Muscle Weakness	YES	NO
Memory Difficulties	YES	NO
Paralysis	YES	NO
Tremors	YES	NO
Dizziness	YES	NO

PSYCHIATRIC

Anxiety	YES	NO
Depression	YES	NO
Difficulty sleeping	YES	NO
Mood swings	YES	NO

HEME-LYMPH

Easy Bleeding	YES	NO
Easy Bruising	YES	NO
Enlarged lymph nodes	YES	NO

ALLERGIES – IMMUNOLOGIC

Allergic Dermatitis	YES	NO
Frequent illnesses	YES	NO
Hay Fever	YES	NO