SHAMOKIN DAM HEALTH CENTER

Confidential Patient Information

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Name *(Last, First, M.I.):*		**SSN #:**
Birthdate:		**Sex:** ☐ M ☐ F
Address:		
City/State/ZIP:		
Home Phone #:		**Mobile/Work Phone #:**
Email:		**Marital Status:** ☐ S ☐ M ☐ D ☐ W
Occupation:		**Employer:**
Employer's Address:		**Employer's Phone #:**
Spouse:	**Employer:**	**Phone #:**
Emergency Contact:		**Emergency Contact Phone #:**
Reason for Visit:		
How did you hear about us?		

Health History (Have you ever been told that you have...) Please check all that apply.

☐ **AIDS/HIV**	☐ **DRUG/ALCOHOL PROBLEM**	☐ **PALPITATIONS**
☐ **ALLERGIES/HAY FEVER**	☐ **EPILEPSY**	☐ **PROSTATE PROBLEMS**
☐ **ASTHMA**	☐ **GLAUCOMA**	☐ **RHEUMATIC FEVER**
☐ **BLEEDING DISORDER**	☐ **HEART DISEASE**	☐ **SPINAL CONDITIONS**
☐ **CANCER**	☐ **HIGH BLOOD PRESSURE**	☐ **STROKE**
☐ **CHRONIC BRONCHITIS**	☐ **HIGH CHOLESTEROL**	☐ **THYROID PROBLEMS**
☐ **CHICKEN POX**	☐ **KIDNEY DISEASE**	☐ **TUBERCULOSIS**
☐ **DEPRESSION/ANXIETY**	☐ **LIVER DISEASE**	☐ **ULCERS**
☐ **DIABETES**	☐ **OSTEOPOROSIS**	☐ **VENEREAL DISEASE**
		☐ **OTHER**

DATE	**REASON FOR SURGERY**	**DATE**	**REASON FOR SURGERY**

MEDICATIONS (INCLUDING VITAMINS, HERBS, AND NON-PRESCRIPTION):

ALLERGIES:

Do you smoke? ☐ **YES** ☐ **NO** **Did you ever smoke?** ☐ **YES** ☐ **NO**

FAMILY HISTORY		
MOTHER	☐ ALIVE ☐ DECEASED	CAUSE:
FATHER	☐ ALIVE ☐ DECEASED	CAUSE:
#_____ SISTERS	☐ ALIVE ☐ DECEASED	CAUSE:
#_____ BROTHERS	☐ ALIVE ☐ DECEASED	CAUSE:
#_____ CHILDREN	☐ ALIVE ☐ DECEASED	CAUSE:
DO YOU HAVE A LIVING WILL/ADVANCE DIRECTIVES?	**☐ YES ☐ NO**	

HEALTH INSURANCE			
Do you have medical insurance? ☐ Y ☐ N	**Do you have Medicare?** ☐ Y ☐ N		
Insurance Company:			
Policy Number:	**Group:**	**Phone:**	
Insured Name:			
Address:			
City/State/ZIP:			

PAYMENT ARRANGEMENTS ARE EXPECTED BEFORE SERVICES ARE RENDERED:

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I HAVE READ AND UNDERSTAND SHAMOKIN DAM HEALTH CENTER'S PRIVACY POLICY.

PATIENT'S SIGNATURE: _____ **DATE:** _____

Person Responsible for Payment

I GIVE PERMISSION TO DISCUSS (initial next to applicable areas):	
	MY MEDICAL CONDITION
	MY TEST RESULTS
	BEHAVIORAL HEALTH (PSYCHIATRIC/PSYCHOLOGICAL) ISSUES
	NOTHING REGARDING MY HEALTHCARE
WITH:	**RELATIONSHIP:**
WITH:	**RELATIONSHIP:**

PATIENT'S SIGNATURE: _____ **DATE:** _____