AUDUBON COUNTY MEMORIAL HOSPITAL
AUDUBON FAMILY HEALTH CARE CLINIC
EXIRA MEDICAL CLINIC

CLINIC PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION:

Patient Name: _____Date of Birth: _____ Home Phone: _____

Mother's Maiden Last Name: _____ Mother's First Name: _____

Address: (Include Street & Box #) _____ Cell Phone: _____

City: _____State: _____ Zip: _____ Soc. Sec. # _____

Email Address: _____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race\Ethnicity: ☐ White ☐ African American ☐ American Indian/Alaskan ☐ Asian ☐ Hispanic/Latino ☐ Pacific Islander ☐ Multiracial ☐ Unknown ☐ Decline

Patient's Employer: _____ Occupation: _____
(Parent's Employer if MINOR)
Employer's Address: _____ Work Phone: _____

Preferred Pharmacy: _____ Address: _____

SPOUSE INFORMATION:

Spouse's Name: _____ Date of Birth: _____

Spouse Soc. Sec. # _____ Employer (Address and phone): _____

EMERGENCY CONTACT: _____RELATIONSHIP:_____ **PHONE**: _____
ADVANCED DIRECTIVES: ☐ YES ☐ NO **COPY: DATE OBTAINED**: _____**OR DATE REQUESTED**: _____

HOUSEHOLD INFORMATION:

List other persons in household: _____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____

INSURANCE INFORMATION:

☐ MEDICARE (Claim ID Number with letter at the end) _____
☐ MEDICAID _____
☐ BLUE CROSS/BLUE SHEILD _____
☐ OTHER INSURANCE _____
☐ NO INSURANCE _____

INSURED NAME: _____ Date of Birth: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

SIGNATURE: _____ **DATE**: _____
(Include relationship, if other than patient)

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS,
RELEASE OF INFORMATION TO INSURANCE COMPANY

I, the undersigned, in consideration for services rendered to the patient by Audubon Family Health Care (AFHC) or Exira Medical Center (EMC) understand and agree to the following:

1. I do hereby voluntarily consent to such diagnostic procedures , hospital care and medical/surgical treatment by AFHC or EMC physicians, physician assistants, nurse practitioners, or physician's designees as is necessary in his/her judgment. I acknowledge that no guarantees have been made to me as the result of treatment or examination in this facility.

2. I hereby authorize and direct payment to Audubon County Memorial Hospital (ACMH), for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance. I authorize ACMH to release any information needed to process my medical claim.

1. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from AFHC or EMC. I will be responsible for any co-payment, deductible, or services not covered by my insurance provider. If I do not have insurance coverage for services rendered by AFHC or EMC, I agree to pay all charges resulting from such services.

2. I understand that my insurance coverage may not provide benefits for routine or preventative care. I understand that it is my responsibility to know my benefits and that I may be financially responsible for services that are not covered. Additionally, I authorize AFHC, EMC and/or ACMH to use a third party lab when necessary in order to process my labs pathology and/or any other testing deemed necessary. It is my responsibility to know which is in network with my insurance company.

3. By providing AFHC, EMC and ACMH with my wireless/cell phone number, I am hereby granting ACMH, and its agents or independent contractors, my consent to receive calls on my wireless/cell phone for billing and debt collection purposes.

4. I acknowledge that I have received a copy of AFHC/EMC/ACMH Notice of Privacy Practice. I understand AFHC/EMC/ACMH has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event the information is revised, a revised Notice will be provided to me at my next visit. I may obtain a current Notice of Privacy Practices at any time from the Privacy Officer at ACMH.

SIGNATURE: _____ **DATE**: _____

(Include relationship, if other than patient)

AUDUBON COUNTY MEMORIAL HOSPITAL
AUDUBON FAMILY HEALTH CARE CLINIC
EXIRA MEDICAL CLINIC

CLINIC PATIENT HISTORY FORM

Name: _____ Date of Birth: _____ Today's Date: _____
FIRST MIDDLE LAST M/D/Y M/D/Y

Home Phone Number: _____ Cell Phone Number: _____

Referred here by (check one): ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of physician/practitioner providing your primary medical care in the past: _____

Date of last Exam: _____ Clinic address: _____

MEDICATIONS

Drug Allergies and reaction: _____

Latex Allergy: ☐ YES ☐ NO

Your Pharmacy Name and City Location: _____

PRESENT MEDICATIONS: (List any medications you are taking; include such items as aspirin, vitamins, laxatives, calcium, etc.

Name of Drug	Dose, Number of pills per day	How long have you taken this medication?	Medication Concerns
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No
Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No Past-How long? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week_____

Has anyone ever told you to cut down on your drinking?
☐ Yes ☐ No

Do you use drugs for reasons that are not medical?
☐ Yes ☐ No If yes, please list: _____

Do you exercise regularly? ☐ Yes ☐ No

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? _____

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: (check all that apply)

☐ Cancer	☐ Heart Problems	☐ Asthma
☐ Psoriasis	☐ Rheumatic fever	☐ Stroke
☐ Cataracts	☐ Tuberculosis	☐ Epilepsy
☐ Glaucoma	☐ High blood pressure	☐ Colitis
☐ Bad headaches	☐ Pneumonia	☐ Parkinson's
☐ Kidney disease	☐ HIV/AIDS	☐ Jaundice
☐ Leukemia	☐ Goiter/Thyroid ds.	☐ Diabetes
☐ Emphysema	☐ Stomach ulcers	☐ Anemia
☐ Depression	☐ Sexually transmitted disease	

Any previous fractures? ☐ Yes ☐ No _____
Any other serious injuries? ☐ Yes ☐ No
If Yes, describe: _____
Other illness/hospitalizations? ☐ Yes ☐ No
Describe: _____

PREVIOUS OPERATIONS

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		

List any natural or Alternative Therapies you use: (chiropractic, magnets, massage, over-the-counter preparations, herbs, etc.)

_____

REVIEW OF BODY SYSTEMS

Do you wear glasses or contacts? ☐ Yes ☐ No

Do you ever have: ☐ Blurred vision ☐ Weak vision

Do you have any of the following? Check all that apply.

☐ Cataracts ☐ Color blindness ☐ Shortness of breath ☐ Chest pain ☐ Sweating spells

☐ Persistent cough ☐ Gas ☐ Heartburn ☐ Belching ☐ Abdominal pain

☐ Nausea ☐ Vomiting ☐ Urinary difficulties

Do you have hearing loss? ☐ Yes ☐ No Do you wear hearing aids? ☐ Yes ☐ No Which ear? ☐ Right ☐ Left

Are your bowels regular? ☐ Yes ☐ No

Have you ever noticed any blood in your urine or stools? ☐ Yes ☐ No If yes, specify: _____

Do you have any urinary difficulties? ☐ Yes ☐ No If yes, specify: _____

Have you ever had: ☐ Unexplained fever ☐ Faintness/passing out ☐ Tremors/shaking

Do you have arthritis or joint pain? ☐ Yes ☐ No If yes, specify affected joints: _____

WOMEN

Menopause: ☐ Yes ☐ No If yes, age: _____

Birth Control method: _____

Number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

FAMILY HISTORY

	Living	**Age or (age at death)**	**List serious illnesses**
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
Sisters	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
Brothers	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	**Which family member?**
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease/AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other serious illness	_____

IMMUNIZATIONS: Pneumonia: ☐ Yes ☐ No If yes, date: _____ Tetanus: ☐ Yes ☐ No If yes, date: _____

SPECIAL DIET: ☐ Yes ☐ No _____

ADVANCED DIRECTIVES: ☐ Yes ☐ No **MEDICAL POWER OF ATTORNEY**: Name: _____

Phone: _____

Date: _____ Patient signature: _____ Provider signature: _____