

Adult Patient Information Sheet

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ E-mail _____

City: _____ State: _____ Zip: _____ SS#: _____

Date of birth: _____ Primary phone #: _____ Secondary phone #: _____

Sex: Male Female Marital Status: Single Married

Employment Status: Full-time Part-time Self-employed Retired Student Unemployed

Employer: _____ Occupation: _____ Phone: _____

Spouse's Name: _____ SS#: _____

Spouse's Date of birth: _____ Spouse's Contact Phone #: _____

Spouse's Employer: _____ Phone: _____

Emergency Contact's Name (other than spouse): _____

Relationship: _____ Phone: _____

Primary Insurance: _____ Primary Policy Holder's Name: _____

SS#: _____ DOB: _____ (We will need to copy your insurance cards.)

Secondary Insurance: _____ Secondary Policy Holder's Name: _____

ACKNOWLEDGEMENT OF RESPONSIBILITY

Payments, co-payments, and insurance deductibles are due at the time of service, unless other arrangement have been made in advance. For those patients that we file insurance for please be advised that the insurance contract is between you and your company, not the insurance company and the doctor. The doctor agrees to see and treat you and to file an insurance claim for you. If you're insurance company doesn't pay in a timely manner (60 days) you will be held responsible for the money due to the doctor for services rendered. We will work with you should this happen. After three notices of payment due (90 days) and your account are still not paid, we will be forced to turn your account over to our collection agency for collection. Should this happen, please be advised that you will also be held responsible for the full amount due plus any interest charged by the collection company.

I authorize the release of any medical information necessary to process my insurance and also my insurance to directly pay the provider of service: (Patient's Initials): _____

I authorize Dr. Andrews' office to leave phone messages on my answering machine. **Yes** or **No**

I acknowledge that I have received the Community Hospitals of Indiana, Inc. and The Indiana Heart Hospital Notice of Privacy Practices: (Patient's Initials): _____

I authorize Dr. Andrews' office to share my Private Health Information with these family members only:

- 1. _____
- 2. _____
- 3. _____

I have read and understand the above statements: (Patient's Initials): _____

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Patient Initials: _____

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act are correct. I authorize my physician who treats me, to release information from my medical records to the Social Security Administration and/ or Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organization for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

Patient Initials: _____

Child Information Sheet

Child's Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth: _____ **Sex:** Male Female **SS #:** _____

Person Responsible for Child's Payment: _____ **Phone#:** _____

With Whom Does the Child Live: _____ **E-mail** _____

Mother's Name: _____ **Maiden Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of birth: _____ **Phone:** _____ **Cell:** _____ **SS#:** _____

Employer: _____ **Phone:** _____

Father's Name: _____ **Date of birth:** _____ **SS#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone#: _____ **Cell#:** _____ **Work#:** _____ **E-mail** _____

Employer: _____ **Phone:** _____

Emergency Contact (other than parents): _____

Relationship: _____ **Phone:** _____

Primary Insurance: _____ **Primary Policy Holder's Name:** _____

SS#: _____ **DOB:** _____ **Relationship to child** _____

Secondary Insurance: _____ **Secondary Policy Holder's Name:** _____

SS#: _____ **DOB:** _____ **Relationship to child** _____

ACKNOWLEDGEMENT OF RESPONSIBILITY

Payments, co-payments, and insurance deductibles are due at the time of service, unless other arrangement have been made in advance. For those patients that we file insurance for please be advised that the insurance contract is between you and your company, not the insurance company and the doctor. The doctor agrees to see and treat you and to file an insurance claim for you. If you're insurance company doesn't pay in a timely manner (60 days) you will be held responsible for the money due to the doctor for services rendered. We will work with you should this happen. After three notices of payment due (90 days) and your account are still not paid, we will be forced to turn your account over to our collection agency for collection. Should this happen, please be advised that you will also be held responsible for the full amount due plus any interest charged by the collection company.

I authorize the release of any medical information necessary to process my insurance and also my insurance to directly pay the provider of service: **(Parent's Initials):** _____

I authorize Dr. Andrews' office to leave phone messages on my answering machine. **Yes** or **No**

I acknowledge that I have received the Community Hospitals of Indiana, Inc. and The Indiana Heart Hospital Notice of Privacy Practices: **(Parent's Initials):** _____

I authorize Dr. Andrews' office to share my Private Health Information with these family members only:

- 1. _____
- 2. _____
- 3. _____

I have read and understand the above statements: **(Parent's Initials):** _____

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

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Patient Initials: _____

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.			
GENERAL <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats MUSCLE/JOINT/BONE Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders GENITO-URINARY <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	GASTROINTESTINAL <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood CARDIOVASCULAR <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	EYE, EAR, NOSE, THROAT <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	MEN only <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other WOMEN only <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____
CONDITIONS Check (✓) conditions you have or have had in the past.			
<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
MEDICATIONS List medications you are currently taking _____		ALLERGIES To medications or substances _____	
Pharmacy Name _____ Phone _____			

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of health	Age at death	Cause of death	Check if a relative had any of the following.	
					Disease	Relationship to you
FATHER					Arthritis, Gout	
MOTHER					Asthma, Hay Fever	
BROTHERS					Cancer	
					Diabetes	
					Heart Disease, stroke	
SISTERS					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					other	

Do you see any specialists? (heart, OB/Gyn, etc.) Please list names & specialties.

Date of last Mammogram _____ Date of last PSA blood test/prostate exam _____

HOSPITALIZATIONS / SURGERIES

Year	Hospital	Reason for hospitalization/surgery

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications (if any)

Have you had a hysterectomy? NO Partial? Or Total?

Have you ever had a blood transfusion? Yes No

If yes, give approximate date/s _____

HEALTH HABITS Check the ones you use & describe how much you use.

<input type="checkbox"/>	Caffeine	
<input type="checkbox"/>	Tobacco	
<input type="checkbox"/>	Drugs	
<input type="checkbox"/>	Other	

Serious illness/injury	Date	Outcome

OCCUPATIONAL CONCERNS

Check if your work exposes you to any of the following:

<input type="checkbox"/>	Stress
<input type="checkbox"/>	Hazardous substances
<input type="checkbox"/>	Heavy lifting
<input type="checkbox"/>	Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

signature

date

Your occupation:



Community

Physicians of Indiana

Parent/Legal Guardian Authorization for Medical Care for Dependent

Name of Dependent: _____

Date of Birth: _____

I (we) _____
(name)

(and) _____
(name)

authorize the following adult _____

to act in my/our behalf in seeking and authorizing medical care and in all respects act as the personal representative for health care for the above named dependent in my/our absence.

Please check the appropriate box below:

This authorization is to remain in effect until _____
(date)

OR

This authorization is to remain in effect until revoke in writing by me/us

Parent/Legal Guardian Signature

Date

Witness Signature:

WELCOME

How were you referred to us?

- Friend or family member
- Insurance company
- Emergency Department
- Referral from a physician _____
- Previous patient of a CPI physician
- Newspaper
- Flyer in the mail
- MedCheck
- Internet Webpage
- Sign on the building
- A relocation guide
- Welcome Wagon
- Community Event/Festival
- Health Screening/health fair
- Other _____

