CHEROKEE REGIONAL CLINICS
PATIENT INFORMATION

(Please complete and return to receptionist) **Today's Date: ____________________**

PATIENT DEMOGRAPHICS

Name:	Birth Date:		Age:
Address:	City:	State:	Zip:
Phone: ( )	Cell: ( )	Work: ( )	
Soc. Security #:	Sex: ☐ Male ☐ Female		
Marital Status: M S W D	Spouse's Name:		
Maiden Name:	Previous Married Names:		
Patient Employer:			
Address:	City:	State:	Zip:
Phone: ( )	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Empl. ☐ Retired		
ETHNICITY: ☐ Hispanic or Latino ☐ Non Hispanic or Latino			
Preferred Language:			
RACE: ☐ White ☐ Black ☐ American Indian or Alaskan Native			
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other:			

MALE HEAD OF HOUSEHOLD/HEAD OF HOUSEHOLD

Name:	Relationship:	Birth Date:	
Phone: ( )	Cell: ( )		
Employer:			
Employer Address:	City:	State:	Zip:
Social Security #:			

EMERGENCY CONTACT INFORMATION

Name of nearest friend or relative:		Relationship:
Home Phone: ( )	Cell: ( )	Work: ( )

INSURANCE INFORMATION

- Please produce your card for a copy to be taken

Primary Insurance Company:	Effective Date:	
Policy Holder Name:	Primary Care Physician:	
Policy Holder Address:	Birth Date:	Policy #:
Secondary Insurance Company:	Effective Date:	
Policy Holder:	Primary Care Physician:	
Policy Holder Address:	Birth Date:	Policy #:
Medicare #:		
Title XIX #:	Medipass Physician:	

FAMILY INFORMATION

Immediate Family Members:	**Previous Physicians (last 5 years):**
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

CHEROKEE REGIONAL CLINICS
CHEROKEE REGIONAL MEDICAL CENTER

CONSENT FOR TREATMENT

I hereby authorize Cherokee Regional Clinics and Cherokee Regional Medical Center to administer such treatment as is necessary.

HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Officer at Cherokee Regional Medical Center.

By signing this form, you acknowledge that a copy of our current Notice of Privacy Practices has been made available to you.

Patient or Patient Representative: ____

Date: _____________________

STATEMENT OF ACCURACY

I confirm that all the information provided on this document is true and accurate.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physicians or the organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signature of Patient: ____

Signed for Patient by: ____

Relationship: _____________________________ Date ________________ Time ___________ AM/PM

Witness: ____

Reason Patient cannot sign: ____

CHEROKEE REGIONAL CLINICS
Teen/Child/Infant History Form

Name: ______________________ DOB: ______________ Date: ______________

Allergies: ____

____

Current Medications (include vitamins): ______________________________

____

Past Surgeries: ____

____

Past Major Injuries (broken bones, concussions, etc.): ______________________

____

Past Hospitalizations: ____

____

FAMILY HISTORY

	Alive	Deceased	Current age or age at death	Cause of Death (if applicable)	Has any blood relative ever had:	Yes	No	Relationship	Age of Onset
Mother					Cancer				
Father					Glaucoma				
Siblings:					Tuberculosis				
1.					Diabetes				
2.					Heart trouble				
3.					High blood pressure				
4.					Stroke				
					Epilepsy				
					Emotional problems				
					Birth defects				
					Suicide				
					Other serious disease				

HOME ENVIRONMENT

Others who live in the same household: ______________________________

____

Does anyone smoke in the home? (circle one): Yes No

Pets in the home? (circle one): Yes No If yes, what kind? ______________________