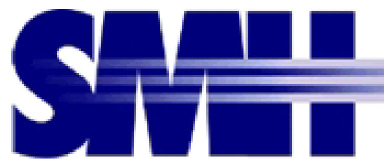


FAMILY HEALTHCARE CENTER

Shelby Memorial Hospital

Dear Patients,

We are glad you have chosen us to be your healthcare provider. Our practitioners are very dedicated to providing the highest quality medical care possible. To better help us care for you, we would like to make you aware of some office policies.

1. **Examinations-** Your health is very important to us. To properly assess for changes in condition of patients who have multiple health issues, we will need to see you in the office approximately every three months. Patients with *minimal* health issues *may* be seen every six months. At these routine visits, we will monitor your blood pressure, order appropriate lab work and assess for adverse effects or needed adjustments to your current treatment.

2. **Scheduling-** We value your time and make every attempt to maintain our scheduled time. We allow 15 minutes for an office call. If you feel you need additional time, we may ask you to reschedule additional appointments to discuss multiple issues.

3. **Missed Appointments-** If you fail to keep a scheduled appointment without canceling, you will be charged $15 missed appointment fee. The fee is your responsibility and is *not billable to insurance.* <u>It must be paid before you can be seen in the clinic again.</u>

4. **Antibiotics-** Antibiotics are not effective against viral illnesses. It is impossible to efficiently assess symptoms over the phone and best practice guidelines call for a face-to-face evaluation before medication is prescribed. If you feel you need antibiotics, we will assist you to schedule an appointment for an evaluation.

5. **Pain Medication-** If your pain medications are not effective as prescribed at your last office visit, you will be asked to schedule an appointment so the physician can reevaluate your change in condition. You may also be asked to sign a controlled substance agreement to prevent misunderstandings about certain medications you may be prescribed for pain management, anxiety or panic disorders.

6. **Cell phones-** We want to give you our undivided attention and we ask that you give us yours by turning off your cell phones when you are in our exam rooms.

As always, we are interested in your healthcare. If you have any questions or concerns, please feel free to contact us at 774-4400.

Thank you,

Family Health Center

200 SOUTH CEDAR STREET
SHELBYVILLE, IL 62565
217-774-4400 PHONE
217-774-6435 FAX

FAMILY HEALTHCARE CENTER- REGISTRATION FORM

PATIENT INFORMATION

Name:____Home Phone:____
Last Name First Name Middle

Address:____City, State________________________Zip_________________

SS#________________Sex ☐ M ☐ F Birth Date_______________ Age______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Referred By____

Patient Employed By____________________________________Work Phone #___________________________________

In case of an emergency, list contact person_______________________________Phone______________________________

Family Physician/ Provider____

Pharmacy ____

Responsible Person *(if different from patient)*

Parent/ Legal Guardian____
Last Name First Name Middle

Relationship to Patient_______________Birthdate__________________________Soc. Sec. #__________________________

Address (if different from Patient's)____Phone______________________

PRIMARY INSURANCE

Is patient covered by insurance? ☐ Yes ☐ No *If yes, please supply us with the Insurance card.*

ADDITIONAL INSURANCE

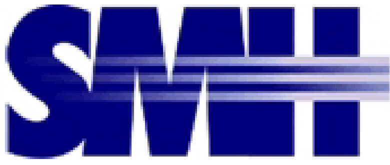
Is there additional insurance? ☐ Yes ☐ No *If yes, please complete below or supply us with the Insurance card.*

Subscribers Name_________________________________Relationship to Patient________Birthdate___________________

Address (if different from Patient's)______________________________________Phone______________________________

Insurance Company____Insurance Phone___________________________

Contract #_______________________________________Group#______________Subscriber#__________________________



SMH Family Health Care Center
200 South Cedar Street
Shelbyville, IL 62565
Telephone 217-774-4400
Fax 217-774-6435

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

TO: Family Healthcare Center
200 South Cedar Street
Shelbyville, Illinois 62565

FROM: ____
(Name of Party/ Provider/ Patient, Requesting/ Receiving Information)

____
(Street Address)

____
(City, State, Zip Code)

You are hereby authorized to release information, which may include:
Medical, mental health, psychological, psychiatric, alcohol,
and/ or drug related information from the medical records of ____________________
(Patient's Name)

____
(Street Address) (City, State, Zip Code) (Birth date)

Date (s) of Care ____________________________________

Nature and extent of information to be released/ submitted/ reproduced:

- ☐ Diagnosis/ Procedures
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ EKG Reports
- ☐ Other (Specify)____________________________

Methods of Release:
☐ Photocopies ☐ Verbal ☐ Fax ☐ Other __________________________

For Purpose of: ____________________________________

The foregoing consent was read, discussed, and signed in my presence. The person so signing did so freely and with full knowledge and understanding. The person further understands that a refusal to consent to the release of the above information will prevent the disclosure of the information without further consent or when mandated by the law. There is the right to revoke the consent in writing at any time. If not revoked in writing, the authorization will expire 90 days from date signed.

Signed______________________________ Date________________
(Patient)

Signed______________________________ Date________________
(Parent, Guardian, Healthcare Power of Attorney)

Signed______________________________ Date________________
(Witness)

The Mental Health and Development Disabilities Act requires that information sought to be specifically identified. A blank consent to the disclosure of unspecified information is not valid. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or is otherwise permitted by 42 CFR Part 2. (Federal Registration June 1, 1987).

FAMILY HEALTH CARE CENTER (RHC)

HEALTH HISTORY INFORMATION FORM

NAME:________________________ SS#:________________ TODAY'S DATE:__________

AGE:________ BIRTH DATE:____________ REASON FOR TODAY'S VISIT:________________________

DATE LAST SEEN BY ANOTHER PHYSICIAN (MONTH/YEAR):________ NAME OF PHYSICIAN LAST TREATED YOU:______________

ALLERGIES- MEDICATION & SUBSTANCES		**MEDICATIONS CURRENTLY TAKING,** INCLUDING OVER-THE-COUNTER		
Name of Medication/Substance	Type of Reaction	Name	Dose	Frequency

SYMPTOMS: Check **symptoms** you currently have or had in the past 3 months

GENERAL

- ☐ chills
- ☐ depression
- ☐ dizziness
- ☐ fainting
- ☐ fever
- ☐ forgetfulness
- ☐ headache
- ☐ loss of sleep
- ☐ loss of weight
- ☐ nervousness
- ☐ numbness
- ☐ sweats

GASTROINTESTINAL

- ☐ appetite poor
- ☐ bloating
- ☐ bowel changes
- ☐ constipation
- ☐ diarrhea
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ gas
- ☐ hemorrhoids
- ☐ indigestion
- ☐ nausea/vomiting
- ☐ rectal bleeding
- ☐ stomach pains
- ☐ vomiting blood

EYE, EAR, NOSE, THROAT

- ☐ bleeding gums
- ☐ blurred vision
- ☐ crossed eyes
- ☐ difficulty swallowing
- ☐ double vision
- ☐ earache
- ☐ ear discharge
- ☐ hay feaver
- ☐ hoarseness
- ☐ loss of hearing
- ☐ nosebleeds
- ☐ persistent cough
- ☐ ringing in ears
- ☐ sinus problems

MEN ONLY

- ☐ breast lump
- ☐ erection difficulties
- ☐ lump in testicles
- ☐ penis discharge
- ☐ sore on penis
- ☐ other:_________

WOMEN ONLY

- ☐ abnormal pap smear
- ☐ bleeding between menses
- ☐ breast lump
- ☐ extreme menstrual pain
- ☐ hot flashes
- ☐ nipple discharge
- ☐ painful intercourse
- ☐ vaginal discharge
- ☐ other:_____________

Date of last menses____________
Date of last pap________________
Date of last mammogram_________
Pregnant? ☐ Yes ☐ No
No. of children___________

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ arms
- ☐ back
- ☐ feet
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ neck
- ☐ shoulders

CARDIOVASCULAR

- ☐ chest pain
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ low blood pressure
- ☐ poor circulation
- ☐ rapid heart beat
- ☐ swelling of ankles
- ☐ varicose veins

SKIN

- ☐ bruise easily
- ☐ hives
- ☐ itching
- ☐ change in moles
- ☐ rash
- ☐ scars
- ☐ sore won't heal

GENITO-URINARY

- ☐ blood in urine
- ☐ frequent urination
- ☐ lack of bladder control
- ☐ painful urination

CONDITIONS: Check **conditions** you currently have or have ever had

- ☐ AIDS/HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer:___________
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Other:____________
- ☐ Chicken Pox
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis (A,B,C)
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Headache: ______________
- ☐ Miscarriage
- ☐ Mono
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempts
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ STD:_____________
- ☐ TB

(OVER)

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer (type)	
	Chemical Dependency	
	Diabetes	
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Health Habits- Check which substances you use and describe how much you use

	Type	Y or N	Past or Present?
	Caffeine		
	Tobacco (how many years) Interested in Quiting?		
	Illicit Drugs		
	Alcohol		
	Other		

Serious Injury	Date	Outcome

Occupational Concerns- Check if your work exposes you to any of the following

	Hazardous Substances
	Stress
	Heavy Lifting
	Other
	Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my health care provider or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________________ __________________

Signature of patient or responsible party Date

______________________________________ __________________

Reviewed by Date