West Caldwell Health Council, Inc.

Collettsville Medical Center
Old Highway 90 / PO Drawer 9
Collettsville, NC 28611
Tel: (828) 754-2409
Fax: (828) 754-2418

Happy Valley Medical Center
Highway 268 / PO Box 319
Patterson, NC 28661
Tel: (828) 754-6850
Fax: (828) 757-3214

PATIENT INFORMATION

Name (Last, First, Middle):_____
Preferred Name: _____
Street Address/PO Box: _____
City/State/Zip: _____

Date of Birth: _____ Social Security Number: _____

Gender: ___ Male ___ Female ___ Unidentified
Marital Status: ___Single ___ Married ___ Separated ___ Widowed ___ Divorced
Home Phone: _____Cell Phone: _____Work Phone: _____
Highest Level of Education (Last grade completed): _____
Place of Employment: _____Occupation: _____
Email Address: _____

Demographics Information:

Race (Choose One):
___ American Indian/Alaska Native
___ Asian
___ Black/African American
___ Native Hawaiian/Other Pacific Islander
___ White
___ Two or more Races

Ethnicity (Choose One): ___ Hispanic ___ Non-Hispanic
Preferred Language (Choose One): ___English ___Spanish Other:_____
Gender Identity: ___ Male ___Female ___TransMan ___TransWoman ___Genderqueer ___Other (Specify) _____
Sexual Orientation: ___Straight ___Gay/Lesbian ___BiSexual ___Other (Specify) _____ Unknown ___

OR I choose not to report Demographic Information. _____(Initial here)

Insurance Information:

Do you have Medical Insurance? YES NO
Primary Insurance Carrier: _____

Do you have Secondary Medical Insurance? YES NO
Secondary Insurance Carrier: _____

Are you covered by a Drug Plan? YES NO

West Caldwell Health Council Inc. offers a Discounted Services Program to low income individuals who qualify.
Would you like information about this program? YES NO

West Caldwell Health Council Inc. offers a Medication Assistance Program to low income individuals who qualify.
Would you like information about this program? YES NO

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

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Patient Questionnaire

In our effort to better serve you and to comply with the privacy regulations mandated by the Governing laws, both Federal and State, we are asking you to take time to complete the following questionnaire and return to us to have for your records.

Sharing of Protected Health Information - Please list the family member or other persons, if any, whom we may inform about your medical condition/diagnosis, or acknowledge your visits here. If none, please write "None".

Name	Relationship	Phone Number

Alternate addresses and telephone numbers, if any - Please print the address (if you do not want to use your home address) where you would like you billing statements and correspondence to be sent.

_____

Please print the telephone number (if you do not want to use your home telephone) where you want to receive calls about your appointments, labs, other medical reports, or other healthcare information _____

May we leave messages on your home/alternate answering machine or voicemail?	YES	NO
May we call you at work?	YES	NO
May we leave a message for you at work?	YES	NO

If YES please print the name of your employer and the telephone number.

_____

Please list the **Pharmacies/Drug Stores/Medical Supply Companies** where you want your prescriptions called, faxed or electronically sent.

_____

_____

Type or Print Name of Patient

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

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STATEMENT TO PERMIT TREATMENT, OPERATION AND PAYMENT OF INSURANCE AND RELEASE OF MEDICAL INFORMATION

By my signature below, I hereby consent for treatment.

_____

Type or Print Name of Patient

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

By my signature, I indicate that I have read the Financial Policy, understand its content and agree to its provisions. I hereby give the West Caldwell Health Council, Inc. clinics a lifetime authorization to submit insurance claims of any kind on my behalf and to receive payment for services rendered at these clinics and all or any of its assignees, associates, or colleagues.

Also by my signature, I authorize the release of any and all protected health information needed to file any insurance claims on a lifetime basis.

_____

Type or Print Name of Patient

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

History & Physical

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NAME _____
DATE _____ SS# _____
ADDRESS _____
OCCUPATION _____ PHONE (HOME) _____
(WORK) _____ DATE OF BIRTH _____
CHIEF COMPLAINT _____
INSURANCE# _____

Hospitalization or Surgery

Date	Reason	Date	Reason

Drug Allergies

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other _____		Cholesterol		Other _____	

Medical History

- ❑ Abdominal Pain - *Chronic* _____
- ❑ Allergies/Hayfever _____
- ❑ Anemia ❑ Bruise Easily _____
- ❑ Ankles - *Swollen* _____
- ❑ Appetite - *Loss of* _____
- ❑ Arthritis/Rheumatism _____
- ❑ Asthma/Wheezing _____
- ❑ Back Pain - *Recurrent* _____
- ❑ Bone Fracture/Joint Injury _____
- ❑ Bowel Habits - *Change in* _____
- ❑ Bronchitis/Chronic Cough _____
- ❑ Cancer _____
- ❑ Chest Pain _____
- ❑ Convulsions/Seizures _____
- ❑ Diabetes _____
- ❑ Diarrhea ❑ Constipation _____
- ❑ Diphtheria _____
- ❑ Diverticulosis ❑ Crohn's/Colitis _____
- ❑ Dizziness/Fainting _____
- ❑ Ear Infections - *Frequent* _____
- ❑ Ear - *Ringing in* _____
- ❑ Eye Infections _____
- ❑ Fatigue - *Chronic* _____
- ❑ Foot Pain ❑ Cold Numb Feet _____
- ❑ Gall Bladder Trouble _____
- ❑ Gout _____
- ❑ Hair Loss _____
- ❑ Headaches - *Frequent* _____
- ❑ Heart Murmur _____
- ❑ Hemorrhoids _____
- ❑ Hernia _____
- ❑ High Blood Pressure _____
- ❑ Indigestion or Heartburn _____
- ❑ Infections - *Frequent* _____
- ❑ Jaundice/Hepatitis _____
- ❑ Kidney Stones _____
- ❑ Lactose Intolerance _____
- ❑ Leg Pain - *Walking* _____
- ❑ Memory Loss _____
- ❑ Mental Illness _____
- ❑ Moodiness - *Excessive* _____
- ❑ Muscle Weakness _____
- ❑ Nausea/Vomiting - *Persistent* _____
- ❑ Nervousness ❑ Depression _____
- ❑ Nose Bleeds _____
- ❑ Numbness/Tingling Sensations _____
- ❑ Osteoporosis _____
- ❑ Phobias _____
- ❑ Pneumonia _____
- ❑ Prostate Disease _____
- ❑ Psoriasis ❑ Eczema _____
- ❑ Rashes ❑ Hives _____
- ❑ Sexual/Menstrual Dysfunction _____
- ❑ Sinus Trouble _____
- ❑ Stools - *Bloody or Tarry* _____
- ❑ Stroke _____
- ❑ Swallowing Difficulty _____
- ❑ Tetanus _____
- ❑ Throat - Sore - *Frequent* _____
- ❑ Thyroid Disease _____
- ❑ Tremor/Hands Shaking _____
- ❑ Ulcers - *Peptic* _____
- ❑ Urethral Discharge _____
- Urination-❑ Overnight > than twice
  - ❑ Decrease in Force/Flow
  - ❑ Painful ❑ Loss of Control
- ❑ Urine - *Blood In* _____
- ❑ Varicose Veins/Phlebitis _____
- ❑ Venereal Disease _____
- ❑ Vision - *Failing* _____
- ❑ Weight Loss - *Recent* _____
- ❑ Chicken Pox ❑ Polio ❑ Mumps
- ❑ Measles ❑ Rubella ❑ Rheumatic Fever
- ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
- ❑ Other _____
- ❑ Other _____

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period _____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method _____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram _____ ❑
❑ Normal ❑ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Hair Loss	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Migraine	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Other _____						

Habits

- ❑ Alcohol: Type _____
  Amount _____
- ❑ Coffee: Cups Daily _____
  Other Caffeine _____
  _____
- ❑ Diet: Salt Intake _____
  Fat Intake _____
  Other _____
- ❑ Exercise Routine: _____
  _____
- ❑ Sleep: Difficulty Falling Asleep _____
  Continuity Disturbances _____
  Early Morning Awakening _____
  Daytime Drowsiness _____
  Other _____
- ❑ Smoke: Packs Daily _____
  How Long _____
  Interested in Stopping? _____

- Food Allergies _____

Do you have a history of Substance Abuse?	YES	NO
Do you use Street Drugs?	YES	NO
Have you ever felt you should cut down on your drinking?	YES	NO
Have people annoyed you by criticizing your drinking?	YES	NO
Have you ever felt bad or guilty about your drinking?	YES	NO
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	YES	NO

_____ _____
Signature Date