SIHF HEALTHCARE

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE NAME | ASSIGNED SEX AT BIRTH

DATE OF BIRTH | SSN

STREET ADDRESS | APT # | CITY | STATE | ZIP

PHONE # | CELL # | EMAIL

LANGUAGE: _____

DO YOU NEED AN INTERPRETOR OR TRANSLATOR? ☐ YES ☐ NO

ETHNICITY: HISPANIC OR LATINO/SPANISH ☐ YES ☐ NO

RACE
☐ WHITE ☐ AMERICAN INDIAN ☐ BLACK
☐ NATIVE HAWAIIAN ☐ ASIAN
☐ PACIFIC ISLANDER ☐ MORE THAN 1 RACE

MARITAL STATUS
☐ SINGLE
☐ MARRIED
☐ DIVORCED
☐ WIDOWED

SEXUAL ORIENTATION
☐ LESBIAN, GAY OR HOMOSEXUAL ☐ BISEXUAL
☐ STRAIGHT OR HETEROSEXUAL ☐ DON'T KNOW
☐ OTHER: _____
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSGENDER/MALE
☐ TRANSGENDER/FEMALE ☐ CHOOSE NOT TO DISCLOSE
☐ GENDER NON-CONFORMING
☐ OTHER: _____

FAMILY SIZE
_____ PEOPLE

FAMILY INCOME
☐ A ☐ B ☐ C ☐ D

(SEE INCOME CATEGORIES SCALE)

ARE YOU A MIGRANT AGRICULTURAL WORKER?
☐ YES ☐ NO

ARE YOU A VETERAN
☐ YES
☐ NO

ARE YOU HOMELESS? ☐ YES ☐ NO IF YES, SELECT HOUSING TYPE: ☐ SHELTER ☐ TRANSITIONAL ☐ STREET
☐ DOUBLING UP ☐ SUPPORTIVE HOUSING ☐ OTHER: _____

EMERGENCY CONTACT NAME | RELATIONSHIP | PHONE # | CELL #

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ UNEMPLOYED ☐ RETIRED

EMPLOYER NAME: _____ WORK PHONE #: _____

PARENT/GUARDIAN OR OTHER PERSON TO BE BILLED (IF DIFFERENT THAN PATIENT)

LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH

STREET ADDRESS | APT # | CITY | STATE | ZIP

FINANCIAL ASSISTANCE

ARE YOU INTERESTED IN RECEIVING ASSISTANCE TO PAY YOUR MEDICAL BILLS WITH SIHF FOR YOU OR A FAMILY MEMBER? ☐ YES ☐ NO

I HAVE INSURANCE BUT WOULD LIKE TO APPLY FOR SMART PAY, SLIDING FEE DISCOUNT, FOR MY DEDUCTIBLE OR COPAY? ☐ YES ☐ NO

OTHER INFORMATION

DO YOU HAVE A HIGH SCHOOL DIPLOMA OR HIGHER EDUCATION? ☐ YES ☐ NO

DO YOU SOMETIMES HAVE TO MISS YOUR MEDICAL APPOINTMENTS DUE TO DIFFICULTY GETTING TRANSPORTATION? ☐ YES ☐ NO

CONSENT

I CONSENT TO RECEIVING COMMUNICATION BY ALL FORMS, INCLUDING AUTO CALLS AND TEXTS ☐ YES ☐ NO

I CERTIFY THAT ALL OF THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE, AND I ACKNOWLEDGE THAT IT IS SUBJECT TO VERIFICATION.

PATIENT/PARENT SIGNATURE: _____ DATE: _____

INSURANCE

☐ INSURANCE CARD COPIED ☐ ID COPIED STAFF MEMBER: _____ DATE: _____

SIHF HEALTHCARE

CONSENT/AUTHORIZATION TO TREAT

SIHF Healthcare provides complete comprehensive health care to the community. This includes hospital, medical, pediatric, OB/GYN, surgical, dental, laboratory, case management, and mental/behavioral health services.

CONSENT FOR TREATMENT: I hereby authorize the above named health care provider to furnish services for all medical, dental, mental/behavioral health, diagnostic procedures, surgical treatment and/or use this information for medical education and research.

COVID-19 MEDICAL CARE CONSENT: As with the transmission of any communicable disease or illness, like a cold or flu, you may be exposed to COVID-19 at any time or any location. SIHF Healthcare adheres to state and federal regulations regarding personal protection equipment for our staff and disinfection and sterilization protocols to limit the potential for transmission. Although the risk of exposure is low, I understand and accept the risks, both known and unknown, and consent to medical care.

_____
Initials

ASSIGNMENT OF BENEFITS TO SIHF HEALTHCARE AND RELEASE OF INFORMATION

I request that payment of authorized Medicare, Medicaid and/or Private Health Insurance benefits be made either to me or on my behalf to SIHF Healthcare for any services furnished to me by that physician/supplier. I authorize the use of an outside laboratory. I authorize any holder of medical information about me to release that information to the Centers for Medicaid & Medicare Services and its agents to include any information needed to determine these benefits or the benefits payable for related services.

I understand some medical charges may not be covered by my insurance and ***I am responsible for any charges that insurance does not pay*** including outside ***laboratory charges***.

_____
Initials

SIHF HEALTHCARE ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I hereby certify that I ***received/refused a copy*** of the Notice of Privacy Practices & Individual

_____
Initials

CONSENT FOR RELEASE OF INFORMATION TO DESIGNATED FAMILY MEMBER OR CAREGIVER

(Do not use this area for other offices, attorneys or organizations)

I, _____ , consent for SIHF Healthcare to release my information to:
Printed Patient Name

_____ _____
Printed Name To Receive Info | Relationship to the Patient

_____ _____
Printed Name To Receive Info | Relationship to the Patient

_____ _____
Patient, Guardian or Representative (Signature Required) | Date

SIHF HEALTHCARE
YOUR HEALTH. OUR MISSION.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____

ADDRESS:_____

SSN:_____ DATE OF BIRTH:_____

I hereby authorize use or disclosure of protected health information about me as described below.

FROM:	TO:
_____	_____
Facility	Company or Individual
_____	_____
Street Address	Street Address
_____	_____
City/State/Zip	City/State/Zip
	_____
	Phone/Fax #

The purpose of this request is:_____

For the dates of service: _____ to _____

Release the Following Information:

☐Complete Health Record	☐Consultation Report	☐History & Physical Exam
☐Immunization Record	☐Laboratory Test Results	☐Nursing Notes
☐Operative Note	☐Physician/Provider Notes	☐Billing Statement/Itemized Bill

Release of Highly Confidential Information:

By checking any box listed below in the category of Highly Confidential Information, I ***specifically authorize*** the use and/or disclosure of the record considered Highly Confidential Information:

(***please check all that apply – leaving a box unchecked will result in that information not being disclosed***)

☐HIV/AIDS Testing or Treatment Records	☐Mental Health Treatment Records
☐Developmental Disabilities Treatment Records	☐Psychotherapy Notes
☐Substance Abuse Treatment Records (Alcohol/Drug)	☐Sexually Transmitted Disease (STD) Records

SIHF HEALTHCARE
YOUR HEALTH. OUR MISSION.

This Authorization will remain in effect (please check one):

☐From the date of this Authorization until:_____ (not to exceed one year)

☐Until Southern Illinois Healthcare Foundation fulfills this request

☐Until the following event occurs:_____

I understand that:

- The information disclosed pursuant to the Authorization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal and state law.
- I may refuse to sign this Authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this Authorization unless my treatment is research related or I am to receive health care solely for the purpose of crating protected health information for disclosure to the Recipient identified in this Authorization.
- I have the right to revoke this Authorization in writing at any time. The revocation will be effective immediately upon receipt by Southern Illinois Healthcare Foundation, except that the revocation will not have any effect on any action taken by Southern Illinois Healthcare Foundation in reliance on this Authorization before it received my written notice of revocation.
- I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation.

I have read and understand the terms of this Authorization. By my signature, I hereby knowingly and voluntarily authorize Southern Illinois Healthcare Foundation to use or disclose my health information in the manner described above.

_____ _____

Patient Signature Date Witness*

If the patient is a minor or is otherwise unable to sign this Authorization, the patient's Personal Representative must sign.

_____ _____

Authorized Personal Representative Date Relationship to Patient

_____

Witness* Date

*Witness signature required for release of Mental Health or Developmental Disability Information.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

SIHF HEALTHCARE

ADULT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ MRN: _____
Last First Mi

Allergies or reactions to medications, foods, latex, or other:

Medication/Food/Other	Reaction

Have you been diagnosed with any of the following?

☐ Acid Reflux/GERD	☐ Cancer	☐ Heart Attack (MI)	☐ Muscle, Joint, or Bone Problem
☐ Allergies	☐ COPD	☐ Heart Failure	☐ Osteoporosis
☐ Anemia	☐ Coronary Artery Disease	☐ Hepatitis	☐ Seizures/Epilepsy
☐ Anxiety	☐ Depression	☐ High Blood Pressure	☐ Skin Problems
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Stroke
☐ Atrial Fibrillation	☐ GI Problems	☐ Kidney/Bladder Problems	☐ Thyroid Problems
☐ Blood Clots	☐ Headaches	☐ Liver Disease	

☐ Other: _____

Have you had any of the following surgeries?

☐ Amputation	☐ Eye Surgery	**Female Related**	**Male Related**
☐ Angio w/ Stent	☐ Gastric Bypass	☐ Bilateral Tubal Ligation	☐ Prostate Biopsy
☐ Appendectomy	☐ Gastrointestinal Surgery	☐ Breast Surgery	☐ Prostatectomy
☐ Arthroscopic Surgery	☐ Heart Surgery	☐ Cesarean Section	☐ TURP
☐ Back Surgery	☐ Hernia Repair	☐ D and C	☐ Vasectomy
☐ Carotid Endarterectomy	☐ Joint Replacement	☐ Hysterectomy	
☐ Cholecystectomy	☐ Knee Surgery	☐ LEEP	
☐ Coronary Artery Bypass	☐ Pacemaker	☐ Mastectomy	
☐ Defibrillator	☐ Tonsillectomy	☐ Myomectomy	

☐ Other Surgical Procedures: _____

SIHF HEALTHCARE

ADULT MEDICAL HISTORY

Family History

		Mom	Dad	Sister	Brother
	Alcoholism				
	Asthma				
	ADD/ADHD				
	Blood Coagulation Disorder				
	Breast Cancer				
	CVA (stroke)				
	Colon Cancer				
	Coronary Artery Disease				
	Dementia				
	Depression				
	Diabetes				
	Disorder of Thyroid				

		Mom	Dad	Sister	Brother
	Heart Disease				
	High Blood Pressure				
	High Cholesterol				
	Kidney Disease				
	Migraines				
	Myocardial Infarction (MI)				
	Osteoporosis				
	Ovarian Cancer				
	Prostate Cancer				
	Other:_____				
	Other:_____				
	Other:_____				

Adult Social History

Tobacco Use (Check One): Current _____ Former _____ Never _____
Type: _____ How much per day? _____ How long? _____
Alcohol Use (Check One): Yes _____ No _____ Former _____
Type: _____ How often? _____ Amount? _____

Health Maintenance

Have you ever had a pneumonia vaccine? Yes____ No____ If yes, what year?
_____
When was your last tetanus vaccine? _____

Have you ever had a colonoscopy? Yes____ No____ If yes, what year? _____

For men age >50 years, have you ever had a PSA? Yes____ No ____ If yes, what year? _____

For women 21-65 years, when was your last pap smear? _____
Have you ever had an abnormal pap smear? _____

SIHF HEALTHCARE

ADULT MEDICAL HISTORY

For women >40 years, have you ever had a mammogram? Yes____ No ____ If yes, what year? _____

Patient Signature: _____ Date:_____