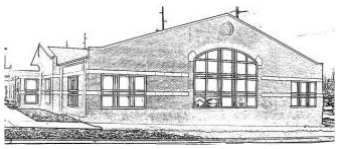

WAYNE COUNTY COMMUNITY HEALTH CENTER
203 EAST MAIN STREET
RICHMOND, IN 47374
PHONE # 765-973-9294 FAX # 765-973-9233
TTY Users call 711

Patient Registration and Health Questionnaire

Date: _____

Each patient must complete a separate Patient Registration and Health Questionnaire

PLEASE PRINT

Name: _____ Date of Birth: _____SS#:_____

Address:_____

City: _____ State:_____ Zip:_____

Phone:_____ Cell Phone:_____ Msg. Phone: _____

Marital Status: S □M □W □D □Sep ☐Male ☐Female E-Mail: _____

Military: ☐Yes ☐ No

Last grade completed _____

Please Circle:
Caucasian/White African American/Black Hispanic/Latino □Native American Asian Other

Employer: _____ Income:_____ Other Income: _____

Employer: _____ Income:_____ Other Income: _____

Insurance & Billing Information
Medicaid #:_____ Self- Pay: ☐ Yes ☐No
Medicare #:_____ □A □B □D
Insurance Name:_____ Policy ID #: _____ Group #:_____

Party Responsible for Payment
Name: _____ Date of Birth: _____ SS#:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Cell Phone:_____ Msg. Phone: _____
Employer: _____ Income:_____ Other Income: _____

HEALTH QUESTIONNAIRE

PLEASE PRINT

How would you describe your current health? □excellent □good □fair □poor
Please list any significant past illnesses. _____
_____
_____
Please list any past surgeries_____
_____
_____
_____

Current Medications	Dose (mg)	How often	Prescribing Dr.	Reason for taking

Do you have allergies? Foods?_____ Medications?_____
_____
Other?_____
Describe allergic reaction _____

FAMILY HISTORY:
If any blood relative has suffered any of the following-please circle the number and indicate which relative.

1) Alcohol	6) Cancer	11) Hay fever	16) Kidney disease	21) Stroke
2) Anemia	7) Diabetes	12) Heart disease	17) Mental illness	22) Thyroid
3) Arthritis	8) Emphysema	13) Hepatitis/liver	18) Migraines	23) Tuberculosis
4) Asthma	9) Epilepsy	14) High blood pressure	19) Osteoporosis	
5) Bleeds easily	10) Glaucoma	15) High cholesterol	20) Stomach problems	

Example: (6) Mother (7) Father

Have you ever been diagnosed with:	Yes	No	When
Abnormal Bleeding			
Arthritis			
Asthma			
Bladder Problems			
Cancer			
Diabetes			
Emphysema			
Heart Attack			
Heart Disease			
Heart Murmur			
High Blood Pressure			
Kidney Problems			
Liver Disease, Hepatitis			
Mental or Emotional Problems			
Seizures			
Stomach Problems			
Stroke			
Thyroid Problems			

I give my consent for The Wayne County Community Health Center Clinic to use and disclose my protected health information (PHI) for treatment, payment, and health care options (TPO). I have received a copy of the NPP. The Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items, and any calls pertaining to my clinical care, including test results. I have the right to request the Clinic to restrict how it uses or discloses my PHI, however, the practice is not required to agree to my restrictions.

I received a copy of the Wayne County Community Health Center, Notice of Privacy Policy.

_____	_____	_____
(Please Print) Patient's Name	Signature	Date

Care Provider Signature:_____ Date:_____