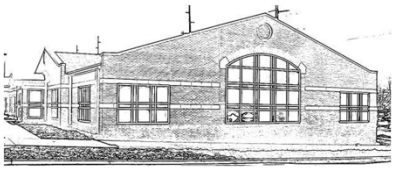
WELL CARE COMMUNITY HEALTH, INC.
203 EAST MAIN STREET
RICHMOND, IN 47374
PHONE # 765-973-9294 FAX # 765-973-9233 TTY Users call 711



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: _____

E-Mail: _____

□ Male □ Female Marital Status: □S □M □W □D □Sep Military: □ Yes □ No

Last grade completed: _____

Circle Race:
American Indian or Alaskan Native, Asian, Black/African American,
Native Hawaiian or Other Pacific Islander, Caucasian/White, Other, Declines to Specify

Circle Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Declines to Specify

Employer: _____ Income:_____ Other Income: _____

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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 received a copy of the Well Care Community Health, Inc. Notice of Privacy Policy.

_____ _____ _____

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

Care Provider Signature:_____ Date:_____