Dove Creek COMMUNITY HEALTH CLINIC
Serving Families Since 1975
MEDICAL • DENTAL • BEHAVIORAL HEALTH

495 W 4th Street – P O Box 576
Dove Creek, CO 81324
www.dovecreekclinic.org
Medical – 970-677-2291 Dental – 970-677-3644 Fax – 970-677-2540

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2018 PATIENT INTAKE FORM

Legal Name: *First* ______________________ *Middle* ______________________ *Last* ______________________

Preferred Name: ______________________ **Date of Birth**: ______________

Race: (check ONE) ❑ White ❑ Native American or Alaskan Native ❑ Asian ❑ Black/African American
❑ Native Hawaiian ❑ Other Pacific Islander ❑ Decline to answer

Ethnicity: (check ONE) ❑ Not Hispanic/Latino ❑ Hispanic/Latino ❑ Decline to answer

Preferred Language: ______________________

Gender Identity: (check ONE)

What sex were you assigned at birth on your original birth certificate?
❑ Male ❑ Female ❑ Choose not to disclose

What is your current gender identity?
❑ Male ❑ Female ❑ Transgender Male/F-to-M ❑ Transgender Female/M-to-F
❑ Other ❑ Choose not to disclose

Sexual Orientation: (check ONE) ❑ Straight (not lesbian or gay) ❑ Lesbian or Gay ❑ Bisexual ❑ Something Else
❑Don't Know ❑ Choose not to disclose

Pronouns Preferred: ❑ He/Him ❑ She/Her ❑They/Them ❑Other______________

Mailing Address: ______________________

____

Home Address: ______________________

Home Phone: ______________________ **Cell Phone**: ______________________

Email: ______________________ **Social Security #**: ______________________

Employer: ______________________ **Work Phone**: ______________________

Are you a U.S. Military Veteran: (check ONE) ❑ Yes ❑ No

What is the BEST way to contact you: (check ONE) ❑ Letter ❑ Phone ❑ Electronic ❑ Portal-medical patients only

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Marital Status: (check ONE) ❑ Married ❑ Domestic Partnership ❑ Single

Please Fill Out Below if You Have a: (check ONE) ❑ Spouse or Domestic Partner ❑ Legal Guardian

Name: ______________________ **Does this person live with you?** ❑ Yes ❑ No

Home Address: ______________________

Home Phone: ______________________ **Cell Phone**: ______________________

Email: ______________________ **Social Security #**: ______________________

Employer: ______________________ **Work Phone**: ______________________

What is the BEST way to contact this person: (check ONE) ❑ Letter ❑ Phone ❑ Electronic

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INCOME VERIFICATION

Your Name: ____ Your Household Size ______

Annual Income for Your Household _____________

You may qualify for sliding fees or discounted services if your income is 250% or below the federal poverty level.
(See Federal Poverty Level Table on the next page)
Please inquire about discounted and sliding scale services at the front desk. We offer payment plans as well.
For more information call 970-677-3658.
!NO ONE WILL BE DENIED SERVICES BASED ON THEIR INABILITY TO PAY!

HOUSING STATUS: ❑ **NOT HOMELESS** ❑ **HOMELESS** (If homeless check applicable box in next row)
❑ Doubling up ❑ Homeless Shelter ❑ Street ❑ Transitional ❑ Unknown

AGRICULTURE STATUS:

1. **Have you or a member of your family ever worked in agriculture/farming, as principal employment, at any time in the past 2 years, including but not limited to field crops, orchards, greenhouses, nurseries, aquaculture, bee keeping, tree farms, work with animals such as cattle, dairy, sheep, poultry, fish hatcheries, etc.?**
   ❑ Yes ❑ No (If YES got to question 3, If NO – got to question 2)
2. **Have you or a member of your family stopped traveling to work in agriculture because of a disability or age?**
   ❑ Yes ❑ No
3. **Have you or a member of your family moved in the past two years to another area (established a temporary home) in order to work primarily in agriculture?** ❑ Yes ❑ No
4. **Have you or a member of your family, worked in the past two years primarily in agriculture, on a seasonal basis, without moving away from your home?** ❑ Yes ❑ No

I verify that the above information is accurate to the best of my knowledge.

Patient or Guardian Signature **Date**

Printed Name of Signer **if not patient, relationship to patient**

Community Health and Dental Clinics receive funds from federal, state and local resources to assist patients. If your income is 250% or below the Federal Poverty Level, you may qualify for reduced costs for services. For more information to see if you are eligible or for an application, ask at the receptionist at the front desk or call 970-677-3658. You may also get an application online at www.dovecreekclinc.org. Affordable payment plans are available as well. Call 970-677-3658 for more information.

Another service offered is Outreach and Enrollment for assistance with purchasing private insurance, as well as obtaining Medicaid and Medicare. We have Certified Application Counselors on staff to assist with enrollment through Connect for Health Colorado and other programs. This is available to patients and non-patients of the clinic. Call 970-677-3657 for more information or to schedule an appointment.

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FEDERAL POVERTY LEVEL GUIDELINES 2018

This page is for informational purposes only.

Persons in Household	48 Contiguous States and D.C. 2018 Poverty Guidelines (Annual)							
	100%	133%	138%	150%	200%	250%	300%	400%
1	$12,140	$16,146	$16,753	$18,210	$24,280	$30,350	$36,420	$48,560
2	$16,460	$21,892	$22,715	$24,690	$32,920	$41,150	$49,380	$65,840
3	$20,780	$27,637	$28,676	$31,170	$41,560	$51,950	$62,340	$83,120
4	$25,100	$33,383	$34,638	$37,650	$50,200	$62,750	$75,300	$100,400
5	$29,420	$39,129	$40,600	$44,130	$58,840	$73,550	$88,260	$117,680
6	$33,740	$44,874	$46,561	$50,610	$67,480	$84,350	$101,220	$134,960
7	$38,060	$50,620	$52,523	$57,090	$76,120	$95,150	$114,180	$152,240
8	$42,380	$56,365	$58,484	$63,570	$84,760	$105,950	$127,140	$169,520
Add $4,320 for each person over 8								

If you household income falls within the categories in the table above, you may qualify for sliding fees or discounted services. Please inquire at the front desk for more information or call 970-677-3658.

- **Household:** A household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household.

- **Family:** A group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

- **Income includes**: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

Community Health and Dental Clinics receive funds from federal, state and local resources to assist patients. If your income is 250% or below the Federal Poverty Level, you may qualify for reduced costs for services. For more information to see if you are eligible or for an application, ask at the receptionist at the front desk or call 970-677-3658. You may also get an application online at www.dovecreekclinc.org. Affordable payment plans are available as well. Call 970-677-3658 for more information.

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Insurance and Payment Information

Patient's Name: ______________________ **Date of Birth:** ________________

Do You Have Medical Insurance or Other Health Coverage?

❑ **Yes** **I have Medical Insurance or Other Health Coverage.** *Please show your card(s) to the Front Desk now.*

1. **What Type of Medical Insurance or Other Health Coverage Do You Have?** (Check all that apply)

   ❑Private (includes Gov't Employee and Vets) ❑ Medicare ❑ Medicaid ❑ CHP+ ❑ CICP ❑ Sliding Scale

2. **Do You Have Prescription Drug Coverage (Check ONE):** ❑ Yes ❑ No

3. **Please Read:** I, the undersigned, certify that I (or my dependent) have Medical Insurance or Other Health Coverage, and assign directly to Community Health Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Community Health Clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Signature:______________________________________**Date**:________________

Printed Name of person signing above:______________________________________

Relationship to patient, if not the patient:

(Check ONE): ❑ Mother ❑ Father ❑ Legal Guardian ❑ Legal Representative

4. **If You Have Medicare, Please Read and Sign This Medicare Authorization:**

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf to Community Health Clinic for any services furnished me by the provider of the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCGS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Community Health Clinic agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:__________________________________**Date**:________________ **Printed Name of person signing above:**__________________________________

Relationship to patient, if not the patient:

(Check ONE): ❑ Mother ❑ Father ❑ Legal Guardian ❑ Legal Representative

❑ No I DO NOT have Medical Insurance or Other Health Coverage - If you do not have health insurance, would you like to receive information on other programs? ❑YES ❑ NO (Please Read):

I, the undersigned, certify that I (or my dependent) do not have Medical Insurance or Other Health Coverage. I understand that I am financially responsible for all charges. I hereby authorize Community Health Clinic to release all information necessary to secure payment for services.

Signature:__________________________________**Date**:________________

Printed Name of person signing above:__________________________________

Relationship to patient, if not the patient: (Check ONE): ❑ Mother ❑ Father ❑ Legal Guardian ❑ Legal Representative

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FINANCIAL RESPONSIBILITY

Who is financially responsible for payment of services rendered for this patient?

❑ **Self (Patient)** ❑ **Other** If you checked **Self** sign at bottom then go to the next page. If you checked **Other**, complete this page.

Name of person financially responsible: ____

Does the patient live with this person: ❑ **YES** ❑ **NO**

Relationship to Patient: ❑ **Father** ❑ **Mother** ❑ **Legal Guardian** ❑ **Other:**___________________________

If the contact information is NOT the same for this person as the patient please complete contact info for this person.

Mailing Address: ____

Physical Address: ____

Home Phone: _________________________________**Cell Phone:** _________________________________

Email: ____ **Social Security #:** __________________________

Employer: _____________________________________**Work Phone:** _____________________________

What is the BEST way to contact this person (check one) ❑ **Letter** ❑ **Phone** ❑ **Electronic**

May this person contact the Clinic or be contacted by the clinic for: (Check all that apply or All of the above)

☐ Emergency ☐ May make my appointments ☐ May discuss my medical and dental conditions

☐ May pick up my medication ☐ May pick up my medical and dental records ☐ May handle billing processes

☐ **ALL of the above**

Is another person also financially responsible? Please complete the following for that person.

Name of person financially responsible: ____

Does the patient live with this person: ❑ **YES** ❑ **NO**

Relationship to Patient: ❑ **Father** ❑ **Mother** ❑ **Legal Guardian** ❑ **Other:**___________________________

If the contact information is NOT the same for this person as the patient please complete contact info for this person.

Mailing Address: ____

Physical Address: ____

Home Phone: _________________________________**Cell Phone:** _________________________________

Email: ____ **Social Security #:** __________________________

Employer: _____________________________________**Work Phone:** _____________________________

What is the BEST way to contact this person (check one) ❑ **Letter** ❑ **Phone** ❑ **Electronic**

May this person contact the Clinic or be contacted by the clinic for: (Check all that apply or All of the above)

☐ Emergency ☐ May make my appointments ☐ May discuss my medical and dental conditions

☐ May pick up my medication ☐ May pick up my medical and dental records ☐ May handle billing processes

☐ **ALL of the above**

I certify that the above is true and correct to the best of my knowledge

Signature:____**Date:**______________________

Printed Name of person signing above:____

Relationship to patient, if not the patient: (Check ONE): ❑ Mother ❑ Father ❑ Legal Guardian ❑ Legal Representative

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Understanding How the Clinic Handles Your Account

Please Read and Initial each item to show your understanding:

Discounts & Ways to Pay

___ I understand that I will receive a 10% discount for paying cash at the time of service.

___ I understand I cannot be refused care due to my inability to pay and that I will be asked for verification of my inability to pay.

___ I understand that I may be offered a short-term payment plan for my account.

___ I understand that I may be eligible for reduced cost of services received and that I must contact the Clinic Eligibility Technician to learn what I must do to qualify for these reduced costs.

What Happens When I Do Not Pay?

___ I understand that I will receive up to 3 statements and should my account remain unpaid, a certified mailing of the statement will be mailed to me.

___ I understand that should my account remain unpaid within 15 days of the certified mailing; my account will be turned over for collections with an outside agency.

___ I understand that if my statement is returned to the clinic as undeliverable, my account will go immediately to collections with the outside agency.

___ I understand that I will be responsible for all costs including Attorney fees and court costs should my account be sent to the outside collection agency.

___ I understand there will be a charge of $25 for all returned item checks. Additional charges will be applied as allowed by CRS 13-21-109.

Refunds

___ I understand that if the Clinic issues me a refund check then I must cash this refund check within six months of issuance or else, after the Clinic as attempted to contact me via all methods of contact authorized by me for the Clinic, the refund check shall be considered a donation to the Clinic.

___ I understand that if the Clinic issues me a refund check that is returned to the Clinic as “undeliverable” then, after the Clinic as attempted to contact me via all methods of contact authorized by me for the Clinic, the refund check shall be considered a donation to the Clinic.

Signature:____**Date:**________________________

Printed Name of person signing above:____

Relationship to patient, if not the patient:

(Check ONE): ❑ Mother ❑ Father ❑ Legal Guardian ❑ Legal Representative

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Clinic Contact Permissions

Patient's Name:_______________________________________**Date of Birth:** ___________________

Who in your family or friends may contact the clinic or be contacted by the clinic?
If you leave this blank, we cannot contact your family or friends in case of emergency.
If you leave this blank, we cannot accept calls from your family and friends for the following services:

Name:_____________________________________Phone:_______________Relationship:________________

☐ Emergency ☐ May make my appointments ☐ May discuss my medical and dental conditions
☐ May pick up my medication ☐ May pick up my medical and dental records ☐ May handle billing processes
☐ **ALL of the above**

Name:_____________________________________Phone:_______________Relationship:________________

☐ Emergency ☐ May make my appointments ☐ May discuss my medical and dental conditions
☐ May pick up my medication ☐ May pick up my medical and dental records ☐ May handle billing processes
☐ **ALL of the above**

Name:_____________________________________Phone:_______________Relationship:________________

☐ Emergency ☐ May make my appointments ☐ May discuss my medical and dental conditions
☐ May pick up my medication ☐ May pick up my medical and dental records ☐ May handle billing processes
☐ **ALL of the above**

Name:_____________________________________Phone:_______________Relationship:________________

☐ Emergency ☐ May make my appointments ☐ May discuss my medical and dental conditions
☐ May pick up my medication ☐ May pick up my medical and dental records ☐ May handle billing processes
☐ **ALL of the above**

Do you have a caregiver?
If someone helps you in your home with taking medications, daily care, making decisions, or someone has POA over you, please fill out the following:

Who gives you daily medications or other medical care?
Name:_____________________________________Phone:_______________Relationship:________________
Name:_____________________________________Phone:_______________Relationship:________________

Who helps you with daily bathing, dressing, feeding, toothbrushing etc?
Name:_____________________________________Phone:_______________Relationship:________________
Name:_____________________________________Phone:_______________Relationship:________________

Who helps you make medical and dental decisions?
Name:_____________________________________Phone:_______________Relationship:________________
Name:_____________________________________Phone:_______________Relationship:________________

Who has Power-of-Attorney (POA) over you? Please bring us legal PROOF OF POA
Name:_____________________________________Phone:_______________Relationship:________________

PLEASE bring us Proof of Guardianship or Legal Custodianship for all Legal Guardians/Custodians listed above.

Signature:____**Date**:______________________

I am: ☐ the Patient ☐ Patient's Spouse or Domestic Partner ☐ Patient's Mother, Father, or Legal Guardian.

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Privacy Notice – Disclosure Permissions – Personal Contact Permission

Patient's Name: ________________________________ **Date of Birth**: ______________________

1. Privacy Notice: Acknowledgement of Receipt of Notice of Privacy Practices and No Show Policy

(Check ONE) **I** ❑ **Have** or ❑ **Have NOT received:**

A copy of the Notice of Privacy Practice for Community Health Clinic and Community Dental Clinic, and a copy of the No Show Policy. I acknowledge that Community Health Clinic and Community Dental Clinic reserve the right to modify both the Privacy Practices outlined in the Notice of Privacy Practice, and the No Show Policy.

2. Disclosure Permissions: Patient Consent for Use and Disclosure of Protected Health Information

(Check ONE) **I** ❑ **DO** or ❑ **Do NOT** **authorize:**

Any previous or current health care providers and organizations to request, disclose, or use Protected Health Information with Community Health Clinic and Community Dental Clinic for the purposes of Medical and Dental treatment, billing, and insurance.

This may or may not include information pertaining to mental health, sexually transmitted diseases, and/or substance and/or alcohol abuse.

3. Personal Contact Permissions: How the Clinic May Contact Me

I understand that Community Health Clinic and Community Dental Clinic may need to contact me from time to time about my treatment, payment, and other health care such as **appointment reminders**, **lab results**, insurance items, among other things.

Community Health Clinic and Community Dental Clinic may contact me in the following ways:

By Phone: (Check ONE for each category)

Home ❑ Detailed message ❑ Leave only a message to call the Clinic phone # ❑ No message
Cell ❑ Detailed message ❑ Leave only a message to call the Clinic phone # ❑ No message
Work ❑ Detailed message ❑ Leave only a message to call the Clinic phone # ❑ No message
Text ❑ Detailed message ❑ Leave only a message to call the Clinic phone # ❑ No message

❑ **Letter** to me at my mailing address.

❑ **Electronic Communication via Clinic Web Portal**

Signature:____**Date**:______________________

If patient is a minor, I am this child's (Check ONE): ❑ **Mother** ❑ **Father** ❑ **Legal Guardian**

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Authorization for Use and Disclosure of Health Information

Patient's Full Name:____Date of Birth:_______________

Best Contact Phone Number: ____

Please tell us about other health care providers you have seen so that we can request your medical records if necessary and better understand your health history.

Choose one below	Your regular Health (Primary) Care Provider?	What to Fill Out
☐ New Patient or not seen here in the last 2 years →	☐ Community Health or Dental Clinic	Fill out ALL 1-4 below
	☐ Someone Else	Fill out 1 only
☐ Seen at this clinic within the last 2 years →	☐ Community Health or Dental Clinic	Fill out 2-4 below
	☐ Someone Else	Fill out 1 only

1. Who is/was your previous regular Health (Primary) Care Provider? (Doctor, Physician Assistant or Nurse Practitioner)

Doctor or Clinic Name:	Address/City/Phone	Patient Signature

2. Do you see any Specialists? ❑ Yes ❑ No

Current Specialists Doctor or Clinic Name:	City/State/Phone	Patient Signature

3. Have you seen any Specialists in the last year that you no longer see? ❑ Yes ❑ No

Previous Specialists Doctor or Clinic Name:	City/State/Phone	Patient Signature

4. <u>IF YOU ARE A FEMALE</u>, have you ever received Well Woman (PAP Smear) care or seen an OB/GYN? ❑ Yes ❑ No

Most Recent Well Woman Doctor or Clinic Name:	City/State/Phone	Patient Signature

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Authorization for Use and Disclosure of Health Information

Patient's Full Name:____Date of Birth:________________

I understand there are Colorado and Federal guidelines about my right to confidentiality and protection of my individually identifiable health information (CFR 42 Part 2, CRS 25.1, HIPAA). Except in situations legally required or permitted, information about me cannot be released to persons or agencies outside the treatment team without my written permission. I hereby authorize Community Health Clinic, Community Dental Clinic, and its providers to send, receive, use or disclose health information about me to the providers I listed on the first page of this Authorization for Use and Disclosure of Health Information form.

(Please check one)

I wish to ❑INCLUDE ❑EXCLUDE any records concerning substance abuse disorder.

Other Important Information:

1. My treatment by Community Health Clinic and Community Dental Clinic does not depend on signing this authorization unless treatment is required by a court or other authorized third party.
2. This authorization will expire in one year. I may revoke my authorization in writing at any time.
3. **I understand and accept that these records may contain documentation of HIV, STD, and drug and/or alcohol information.**
4. Copies of this form may be used in lieu of the original. Signatures received by fax will be accepted.
5. Community Health Clinic and Community Dental Clinic cannot guarantee that recipients of information disclosed through this authorization will not be re-disclosed to another party. The recipient may or may not be subject to federal laws protecting health information.

____________________ ________ ____________________
Patient Signature Date Witness Signature

____________________ ________ ____________________
Representative Signature Date If Representative, relationship to patient

REVOCATION: I revoke my authorization for this use and disclosure of my health information.

____________________ ________ ____________________
Patient/Representative Signature Date Witness Signature

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MEDICAL HISTORY

Patient's Name: ______________________________ Date of Birth: ______________

		If "Yes", please briefly explain:
Are you under a physician's care now?	❑ Yes ❑ No	
Have you ever been hospitalized or had a major operation?	❑ Yes ❑ No	
Have you ever had a serious head or neck injury?	❑ Yes ❑ No	
Do you use marijuana for medical or recreational purposes?	❑ Yes ❑ No	
Do you use alcohol?	❑ Yes ❑ No	
Do you use any other illicit drugs?	❑ Yes ❑ No	
Are you on a special diet?	❑ Yes ❑ No	
Do you take supplements, such as vitamins, etc.?	❑ Yes ❑ No	
Women Only – Are you… ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?		

Certain medical problems or medications may affect your health and treatments we provided. Please answer the following questions.

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❑ Yes ❑ No	Dizziness	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Breathing Problems	❑ Yes ❑ No	Heart Trouble	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Stomach Disease	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No	Intestinal Disease	❑ Yes ❑ No
Cold Sore	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Fever Blisters	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Convulsions	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Steroids/Prednisone Meds	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Drug Addiction	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Easily Winded	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Emphysema / COPD	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Epilepsy or Seizures	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No		
Excessive Bleeding	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No		
Excessive Thirst	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No		
Other Serious Disease not listed (please explain):					

To the best of my knowledge, I accurately answered the questions on this form. I understand that providing incorrect information about the patient can be dangerous to the patient' health. I will inform the medical office of any changes in medical status.

Signature: ______________________________ Date: ______________

If the patient is a minor, I am the child's (CHECK ONE) ❑ Mother ❑Father ❑ Legal Guardian