Family Health Care Clinic

605 W Lincoln • Lindsborg, KS 67456 • 785-227-3371 • FAX 785-227-3004

Patient Registration (Please Print)

Office Use Only:
Financial Services
Provider

Patient's Legal Name (Last, First, MI) Male: Female:

Birth Date Social Security Number College ID:

Address City

State Zip Code: Work Phone: Other Phone:

Primary Phone Is this cell or home? Cell Home

E-mail Address Which practitioner are you requesting?

Previous Primary Care Physician Phone

Address (Street, City, State, Zip)

For Minors: Parents name(s) **Phone**

Secondary (college) Address

Permission to obtain records of all medications from all pharmacies: YES NO

Primary Health Insurance:

Company Policy Number Group Number

Cardholder Name Cardholder Birth Date

Secondary Health Insurance:

Company Policy Number Group Number

Cardholder Name Cardholder Birth Date

Billing Information: Check here if same as above:

Name Social Security Number

Phone Number Relationship to patient

Address (Street, City, State, Zip)

Notify in Case of Emergency:

Name Relationship

Address (Street, City, State, Zip)

Home Phone Cell Phone Work Phone

Patient Demographic Information: Circle all that apply

Gender: Male Female Marital Status: Single Married Divorced Widowed Ethnicity: Hispanic Non-hispanic

Race: White/Caucasian Black/African American American Indian/Alaska Native Asian

Native Hawaiian/Pacific Island Other Unknown/decline to answer Preferred Language:

Please present your insurance ID card and the required co-pay at the time of each visit. Payment in full at the time of service is expected unless other arrangements have been made. The patient is responsible for all required referrals and for payment if your insurance does not cover charges for lab tests and/or procedures.

Patient / Guardian Signature_____ **Date** _____

Lindsborg Community Hospital
Salina Regional Health Center

Family Health Care Clinic

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www.lindsborghospital.org

RELEASE OF HEALTH INFORMATION

I, _____, date of birth _____, give permission
patient's name

for the Providers and nursing staff of Family Health Care Clinic to discuss (or print) my medical issues and care with

name	daytime phone number	relationship

I, _____, give permission for the Providers and
print patient's name
nursing staff of Family Health Care Clinic to contact pharmacies for a list of my medications.

Please do not write below this line until you come to the clinic.

****

This designation revokes prior elections and will remain in effect until I revoke this election in writing.

Date Signed

Date Witnessed

10.15.15

Lindsborg Community Hospital
Salina Regional Health Center

Family Health Care Clinic

785-227-3371 for appointments or questions
605 W Lincoln • Lindsborg, KS 67456 • FAX 785-227-3004 • www.lindsborghospital.org
Please use ink to complete the form. If you need assistance to complete this form, please ask.

ADULT MEDICAL HISTORY

DATE THIS FORM COMPLETED:

LEGAL NAME: PREFERRED NAME:

DATE OF BIRTH: PLACE OF BIRTH (City/State/Country):

CURRENT MEDICATIONS. PLEASE LIST **NAME OF MEDICATION, DOSAGE YOU ARE *NOW* TAKING, AND DIRECTIONS.**

Medication Name	*Strength (mg, cc, etc)*	*Directions (frequency, etc)*

(You may use an additional sheet of paper in order to provide ALL information)

PLEASE LIST ANY ALLERGIES YOU HAVE TO MEDICATIONS AND WHAT THE REACTION WAS.

Medicine	Type of reaction/approx. date

YOUR PAST MEDICAL HISTORY *(please check all that apply)* ☐ Headaches ☐ Seizures ☐ Heart Disease ☐ Diabetes
☐ Anemia ☐ Lung Disease ☐ Ulcers ☐ Elevated Cholesterol ☐ Elevated Blood Pressure ☐ Thyroid Problem ☐ TB
☐ Stomach Problem ☐ Colon Trouble ☐ Depression /Anxiety ☐ Chronic Pain
Cancer History ☐ Breast ☐ Colon ☐ Prostate ☐ Skin ☐ Other: *(specify)*

PLEASE LIST ANY SERIOUS OR CHRONIC ILLNESS OR INJURIES:

SURGICAL HISTORY: (check all that apply)

☐ Appendectomy **date:**
☐ Cholecystectomy *(gallbladder)* **date:**
☐ Hysterectomy **date:**
☐ Tonsillectomy **date:**

Other surgical history: ***(include nature and approximate date)***

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ◯ **YES** ◯ **NO** ◯ **DON'T KNOW** Date:

SOCIAL HISTORY

MARITAL STATUS? **TOBACCO USE?** ◯ **current** ◯ **former** ☐ **packs/day** Quit Date:
OCCUPATION: **HOW LONG AT THIS TYPE WORK**
NUMBER OF CHILDREN **ALCOHOL USE?** ◯ Yes ◯ No
OTHER?

Most recent Primary Care Provider? *(name)* *(address)*
Other Current Medical Provider(s)?

IMMUNIZATION AND PREVENTATIVE HEALTH SERVICES

VACCINE	*LAST DATE*
Pneumococcal	
Influenza	
Hepatitis B	
Tetanus	
Shingles	

Last Colonoscopy Date: Next One Due:
Last Mammogram Date: Next One Due:
Last Pap Smear Date: Next One Due:
Other

Childhood immunizations up-to-date? ◯ Yes ◯ No

FAMILY HISTORY

Father's age *If deceased, age at death* *cause*
Other diseases:
Mother's age *If deceased, date at death* *cause*
Other diseases:
OTHER FAMILY: (name, age, medical issues. If deceased, age at death and cause of death)
Brother/Sister
Brother/Sister
Brother/Sister
Paternal Granamomer
Paternal Grandfather
Maternal Grandmother
Maternal Grandfather

Print **Clear Form**