Family Health Care Clinic

A department of Lindsborg Community Hospital
605 W Lincoln • Lindsborg, KS 67456 • 785-227-3371 • FAX 785-227-3004

Office Use Only:
Financial Services
Provider

Patient Registration (Please Print)

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

Birth Date Social Security Number College ID:

Address (Street, City, State, Zip)

Home Phone Cell Phone Work Phone

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: Check all that apply

Male Female Single Married Divorced Widowed Hispanic Non-Hispanic
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

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PEDIATRIC MEDICAL HISTORY

Please answer all questions as completely as possible in ink.

Date form completed Name of Adult completing this form

Child's Legal name Preferred name

Date of birth Place of birth (city/state)

Born at: Expected Due Date Early Late Complications during pregnancy? Yes No

Weight at birth Length at birth Complications after birth? Yes No

Type of Delivery: Vaginal Cesarean Released from hospital at what age?

Surgical History List all operations child has had in the past and the approximate age at time of the surgery

Hospitalizations (other than for surgery) List reason for hospitalization and approx age

Serious or chronic illnesses or injuries (for example: diabetes, cancer, heart disease, HIV, asthma, developmental delays)

Allergies or bad reactions to medications:
Name Type of Reaction

Who has been child's primary doctor for the past two years? (name) (city)

Current Medications: (including aspirin, vitamins, supplements, birth control)
Name of Medication Reason for using this medication

Patient's Habits (if applicable)

Does anyone who lives with this patient smoke cigarettes? Yes No Don't know Who?
Do you (patient) use any type of tobacco? Yes No What type? How much?
Do you (patient) drink any alcoholic beverages? Yes No Type How frequently?
Do you use any drugs which are considered "recreational drugs"? Yes No

PEDIATRIC MEDICAL HISTORY

Vaccines / Immunizations

Is your child immunized as recommended for children in the State of Kansas? Yes No

Please attach a copy of all immunizations and dates given.

Family History

Is there anv additional information that you think doctor should know about this child?

Family History	Name	Age (if living)	Health Problems (if living)	Age at Death (if deceased)	Cause of Death (if deceased)
Father					
Mother					
Brother / Sister					
Brother / Sister					
Brother / Sister					
Brother / Sister					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Has any other relative (of patient) had:			What relatives? (grandparent, Aunt, Uncle, Cousin)
Cancer of the breast	No	Yes	
Cancer of the colon	No	Yes	
Other cancer			
Diabetes	No	Yes	
Heart attack	No	Yes	
Stroke	No	Yes	
High blood pressure	No	Yes	
Sudden death before 50	No	Yes	
Liver disease or hepatitis	No	Yes	
Kidnev disease	No	Yes	
Thyroid disease or goiter	No	Yes	
Mental illness	No	Yes	
Asthma	No	Yes	
Overweight	No	Yes	
Alcoholism / Drinking problem	No	Yes	

Form reviewed by ______________________________ (office staff) ____________ (date)

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RELEASE OF HEALTH INFORMATION for **MINORS**

I, ____, parent or legal guardian of
(print name)

____, date of birth __________,
Patient's name

give permission for the Providers and nursing staff of Family Health Care Clinic to discuss my child's medical issues and care with:

Name	daytime phone number	relationship
Name	daytime phone number	relationship
Name	daytime phone number	relationship
Name	daytime phone number	relationship
Name	daytime phone number	relationship

I, ____, parent or legal guardian of
(print name)

____, date of birth __________,
Patient's name

give permission for the Providers and 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.

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

____________________ __________________________________
Date Signed

____________________ __________________________________
Date Witnessed