STILLPOINT

Date _____

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Gender: _____ Marital Status: _____

Race/Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: _____

What language do you speak at home? _____

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

What is your occupation? _____ Employer: _____

Whom may we thank for referring you? _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

Please List Your Current and Previous Medical Conditions

Cancer Where or what type? _____
Cardiovascular ☐Heart Failure ☐High Blood Pressure Other: _____
Endocrine ☐ Diabetes ☐ Thyroid Other: _____
Gastroenterology ☐ Stomach Ulcer ☐ Reflux ☐ Bowel Other: _____
Hematology ☐ Blood disorders ☐ Blood clots Other: _____
Infectious Disease ☐ Hepatitis ☐ Tuberculosis ☐ HIV Other: _____
Neurological ☐ Seizures ☐Stroke ☐Migraine Other: _____
Nephrology ☐ Kidney Disease ☐ Hypertension Other: _____
Rheumatology ☐ Arthritis ☐ Fibromyalgia ☐ Gout Other: _____
Respiratory ☐ Asthma ☐ COPD ☐ Sleep Apnea Other: _____
Vision or Hearing Problems: _____
Other physical problems, not mentioned above: _____

Please List all Current Medications, Vitamins and Herbal Remedies

Medication and Dose	Date Started	Side effects (if any)	Prescribing doctor

If more space is needed, please write on a blank sheet of paper.

Please list any known allergies: _____

Person Responsible for Payment on Account

Please provide the information of the person responsible for paying remaining balances:

Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance

Are you involved in a worker's compensation case? Yes No

Will you be using health insurance to pay for part of your visit(s)? Yes No

What is your relationship to the policy holder: Self Spouse Child Other: _____

Insurance Company: _____ Policy & Group Number: _____

Complete this section if the patient is not the insurance policy holder.

Policy holder: _____ Date of Birth: _____ Social Security #: _____

Please provide the policy holder's address and phone number below.

Policy holder's full address: _____

Policy holder's phone number: _____

Assignment of Benefits & Consent for Treatment

In presenting for diagnosis and treatment, I hereby voluntarily consent to the rendering of such care. I hereby assign, transfer and set over to Provider, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. I certify that the information given is correct. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company; or of any balance due after payments by my Insurance Company. I agree to pay any balance due in full no later than 30 days of statement, unless other arrangements have been made in advance.

Signature _____ **Date** _____

We request that you notify our office of any changes in the following information: name, address, phone number, change in insurance, or change in marital status**.**

Appointment Confirmation

We will attempt to contact you to confirm each appointment approximately two working days ahead of time. This is a *courtesy*, and our failure to reach you will not relieve you of your responsibility for any missed appointment charges. I wish to be contacted in the following manner (select *one*):

☐ Do not contact me to confirm my appointment

☐ Confirm by email

☐ Send a text message to: _____

Call my: ☐ Home ☐ Cell ☐ Work Phone Number _____

Authorization for the Use or Disclosure of Health Information

It is important for your **primary care doctor** to have all of your medical information to ensure that you receive the best care possible. The purpose of sending the health information to your doctor is to assist in identifying any follow-up medical care that may be needed. In addition, Licensed Clinical Social Workers are required by Illinois law to inform a patient's doctor that they are in counseling, unless the patient indicates they do not want any information shared. If you choose to let us share information with your doctor, please provide their name and address.

Please check **one** of the following boxes:

- ☐ I do not have a primary care doctor.
- ☐ I authorize the release of all information pertaining to any of my medical history, mental or physical condition, and treatment received, which may include personal drug and/or alcohol usage.
- ☐ I authorize only the release of my diagnosis and any medications or treatment options my doctor or therapist prescribes.
- ☐ I DO NOT authorize the release of any personal health information.

Your Primary Care Doctor's Name: _____

Address: _____

Phone: _____ Fax: _____

Would you like us to send the same information to your therapist or counselor? ☐ Yes ☐ No ☐ N/A

If yes, please provide their name and address:

Name: _____

Address: _____

Patient or Guardian Signature: _____ Date: _____