Patient Information

Crossing HEALTHCARE

320 East Central Avenue
Decatur, Illinois 62521
(217) 877-9117

Date:

Home Phone:

Date: | Medical Record Number: | Cell Phone:

Name: Last First Middle | ☐ F ☐ M | Date of Birth:

Address: City State Zip

Status:
Single ☐ Separated ☐
Married ☐ Widowed ☐
Divorced ☐

Unempl ☐ Employee ☐
Student ☐ Retired ☐

Veteran
☐ No ☐ Yes

Social Security Number:

Race/Ethnic Origin:
White ☐ Asian ☐
Black ☐ Other ☐
Hispanic ☐

Household Income: # in Household: _____
☐ $0-$10,000 ☐ $30,000-$40,000
☐ $10,000-$20,000 ☐ $40,000 and over
☐ $20,00-$30,000

Other Form of Payment:
❑ Cash ☐ Social Security ☐ Other: _____

Person to be called in case of emergency: | ❑ Relative ❑ Friend | Work Phone:

Parent/Guardian Information (if different from the patient)

Mother's Name:	Father's Name:
Employer:	Employer:
Date of Birth:	Date of Birth:
Mother's Social Security #:	Father's Social Security #:

Patients Guardian if Other than Mother/Father: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Employer: _____ Date of Birth: _____

General Consent:

I consent to the performance of routine treatment as may be considered necessary or advised by Crossing Healthcare.
Signature: _____ Date: _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information, have completed the above answers and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information including all insurance information.

Signature of Patient, Parent, or Responsible Party: | Date: (today)

Medical Problems & Conditions: _____

Medication & Dose: _____

Allergies: _____

Previous Hospitalization & Surgeries: _____

Authorization to Release Health Information

Name of Patient (Please Print) _____ Maiden Name (*if applicable*) _____

Address _____ City _____ Date of Birth _____

I, the undersigned, authorize (PLEASE **ONLY** MARK WHERE YOU **HAVE BEEN** IN THE LAST **5 YEARS**.) to release any and all records:

- ☐ Decatur Memorial Hospital - Medical Records
- ☐ St. Mary's Hospital - Medical Records
- ☐ DMH Express Care
- ☐ Macon County Health Department
- ☐ Department of Corrections **(Another form will need to be filled out if it has been within the last 5 years)**.

☐ Name of Family Doctor: _____ Phone#: _____
Name Address

☐ Specialty Doctor: _____ Phone#: _____
Name Address

☐ Additional Doctors: _____ Phone#: _____
Name Address

_____ Phone#: _____
Name Address

To disclose/release the above named individual's health information to Crossing Healthcare Provider: _____

Crossing Healthcare
320 E. Central Avenue
Decatur, IL 62521
(217) 877-9117

Medical Records Fax Number: (217) 877-3079

For the purpose of: Medical Treatment
Specific information to be released (with dates where appropriate): Other Information: _____

- ☒ Most recent Physician progress notes
- ☒ Mental Health History
- ☒ Medical History: Examinations and Lab Tests
- ☒ Medication and Problem List
- ☒ Immunizations
- ☒
- ☒ Dates Ranging from: **ADULTS: January 1, 2013 – Present / Pediatric Patients: ALL MEDICAL RECORDS**

Please initial next to each statement:

- ☐ _____ This authorization specifically authorizes you to disclose records of alcohol and/or substance abuse.
- ☐ _____ This authorization specifically authorizes you to disclose information regarding infectious disease, sexually transmitted disease, HIV or AIDS.
- ☐ _____ This authorization specifically authorizes you to disclose information regarding mental health services.

Signature: _____ Date: _____

RECORDS

I understand that I may revoke this authorization in writing at any time, except to the extent that my healthcare provider has already taken actions in reliance on it. If not previously revoked, this authorization will expire 6 months from the date of my signature.
I understand that information disclosed may be subject to re-disclosure and no longer protected by Federal Privacy Regulations. I understand this authorization is voluntary and is not necessary to assure treatment. I may receive a copy of this authorization upon request.

Signature of Patient/Parent/Legal Guardian * _____

Relationship to Patient: _____ **Date:** _____

Witness Signature: _____ **Date:** _____