

DATE _____ Do you have an appointment? **(Check One)** YES or NO *If yes, what time?* _____

Have you ever been seen by the Christian County Health Department before today? **(Check One)** YES or NO

Have you traveled outside the United States during the past 3 weeks (21 days)? **(Check One)** YES or NO

If YES, did you travel to any of the West African countries? **(Check One)** YES or NO

Have you knowingly been in contact with anyone that has been outside of the United States during the past 3 weeks (21 days)? **(Check One)** YES or NO

(Please only list patients with an appointment) (WIC Appointments- List All household members receiving WIC)

Patient Name: _____ Date of Birth: _____ SS #: _____ Race: ___ M/F
(First, Middle, Last) (MM/DD/YYYY)

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(First, Middle, Last) (MM/DD/YYYY)

Patients Current Mailing Address: _____
(PO BOX or Street Address) (City) (State) (Zip)

Guardian's Name (if under 18) _____ Relationship: _____

Is the guardian present for the appointment today? **(Check One)** YES or NO

Home Phone Number _____ Cell Phone Number _____ How many people in Household _____

Your Email address: _____ I agree to receive text Yes / Email appointment reminders

Do you have Medicaid? **(Check One)** YES or NO

Coventry/Aetna Passport Wellcare Humana Caresource Anthem

Do you have Medicare? **(Check One)** YES or NO

Do you have Medical Insurance? **(Check One)** YES or NO *If yes, please list insurance provider(s):* _____

What services are you scheduled for today? **(Check all that apply)** *** Represents WOMEN ONLY**

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Medical Nutrition | |
| <input type="checkbox"/> Blood Sugar | <input type="checkbox"/> WIC | <input type="checkbox"/> Records Request | <input type="checkbox"/> *Pregnancy Test <small>last menstrual cycle</small> |
| <input type="checkbox"/> Cancer Screening | <input type="checkbox"/> Flu Shot or Nasal Mist | <input type="checkbox"/> School Physical | <input type="checkbox"/> *Family Planning Exam/Pap |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Formula/Package Change | <input type="checkbox"/> Well Child Exam | <input type="checkbox"/> *Sexually Transmitted Disease |
| <input type="checkbox"/> Dental Varnish | <input type="checkbox"/> Immunizations | <input type="checkbox"/> TB Skin Assessment/Reading | *Are you on your period? |
| <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> Yes or <input type="checkbox"/> No |

FOR STAFF USE ONLY

Appt. Time: _____ Scheduled Provider # _____ Arrival Time: _____ Clerk: _____

Chart to Clinic: _____ Nurse: _____ Nurse Call Pt Time: _____ Services Completed: _____