CCHD
Christian County Health Department

(Revised April 2018)

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)

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

Patient Name: _____ **Date of Birth:** _____ SS **#:** _____**Race:**____ M/F
(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***

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

FOR STAFF USE ONLY

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

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