



COUNCIL BLUFFS
COMMUNITY
HEALTH CENTER

300 West Broadway, Suite 6
Council Bluffs, IA 51503

Telephone (712) 256-9151

Fax (712) 325-0288

Patient Information

Last Name _____ First Name _____ MI _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Best Time to Call _____

Date of Birth _____ Social Security Number _____

Gender _____ Marital Status _____ Race _____

Language _____ Religion _____ Resident County _____

Birth City _____ State ____ Military Status _____ Student Status _____

Responsible Party Information

Last Name _____ First Name _____ MI _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Best time to call _____

Date of Birth _____ Social Security Number _____

Employer _____

Employer Address _____

Relationship to Patient _____ Language _____

*The responsible party is the family member who is covered by the insurance company or head of household. This is the person who will be responsible for any bills and receive all statements regarding the account.

Dental Insurance Information

Insurance Company _____

Policy Number or ID _____ Group Number _____

* Be aware that all deductibles, co insurance, and minimum fee's are due at the time of service. CBCHC accepts cash, check, or credit.

Have we seen anyone else from your household? YES NO (circle one)

If yes, Name: _____ Relationship to patient: _____

Emergency Contact Name: _____ Telephone _____

Allergies

Latex Y or No

Local Anesthetics Y or No

Penicillin Y or No

Medication Allergies Y or No

If so please List: _____

Health History

Recent Illness/Surgery	Y or N	Diabetic	Y or N
Pregnant	Y or N	Asthma	Y or N
Smoker	Y or N	Tuberculosis	Y or N
Heart Trouble/Surgery	Y or N	Stomach Problems	Y or N
Chest Pain	Y or N	Kidney Problems	Y or N
High Blood Pressure	Y or N	Cancer	Y or N
Stroke	Y or N	Convulsions	Y or N
Rheumatic Fever	Y or N	Seizures	Y or N
Heart Murmur	Y or N	Fainting	Y or N
Anemic	Y or N	Prolonged Bleeding	Y or N
Thyroid trouble	Y or N	Syphilis	Y or N
Jaundice	Y or N	Gonorrhea	Y or N
Hepatitis	Y or N	Social Herpes	Y or N
Liver Problems	Y or N	AIDS	Y or N
Arthritis	Y or N	Bone Disease	Y or N
Joint Problems	Y or N	Joint Replacement	Y or N
Eye Problems	Y or N	Drug/Alcohol Abuse	Y or N
Sudden weight loss/gain	Y or N	Lumps neck/armpit/groin	Y or N
Discolored areas	Y or N	Night Sweats	Y or N
Prolonged Fever	Y or N		

Other Conditions: _____

Medications

Cortisone/Steroids, anti rejection drugs	Y or No
Blood Thinners	Y or No
Tranquilizers, sedatives, or pain drugs	Y or No
X-ray or radiation treatment for cancer	Y or No
Nitroglycerin or other hear medications	Y or No

Any Other Medications: _____

Patient/ Guardian Signature

Date

CBCHC Representative