Crossing HEALTHCARE

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

NEW PATIENT INFORMATION			
Name			Date
Date of Birth Month/ Day/ Year		Social Security Number	
Address:	City:	State:	ZIPCODE
Billing Address (if different from above)	City:	State:	ZIPCODE
Home Phone	Cell Phone	Work Phone	Best to Use
Email Address:		Sex Assigned at Birth: ☐ Male ☐ Female	
Age 18 and older: Do you think of yourself as: ☐ Straight/ heterosexual ☐ Gay/ Lesbian/ Homosexual ☐ Bisexual ☐ I don't want to answer ☐ I don't know	Age 18 and older: Current Gender Identity: ☐ Female ☐ Male ☐ I don't want to answer ☐ Transgender Female ☐ Transgender Male ☐ Neither exclusively male or female	Age 18 and older: Preferred Pronouns: ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir ☐ I don't know ☐ I don't want to answer ☐ Other _____	Preferred Language: ☐ English ☐ Español ☐ Arabic ☐ Chinese ☐ Indian ☐ Other_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____	Employment Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Student Full Time ☐ Student Part Time ☐ Retired ☐ Unemployed ☐ Other _____	Race: ☐ African American/ Black ☐ Asian ☐ Caucasian/ White ☐ Native/ Alaskan American ☐ Pacific Islander ☐ Other _____	Ethnicity: ☐ Hispanic/Latino/ Latina ☐ Not Hispanic/ Latino/Latina ☐ Unknown Veteran Status: ☐ Veteran ☐ Not a Veteran
Emergency Contact Name	Phone Number		Relationship to You
Are you (or the patient) taking medicine for ADHD or been diagnosed with ADHD? ☐ Yes ☐ No Are you (or the patient) pregnant?/ Need to see an OB/Gynecologist? ☐ Yes ☐ No			
Complete this Section if the Patient is age 17 or younger and/or has a Guardian			
Mother's Name		Father's Name	
Employer		Employer	
Date of Birth		Date of Birth	
Mother's Social Security Number		Father's Social Security Number	
Parents/ Guardian if other than Mother/Father:_____ Address: _____ City: _____ State: ____ ZIP_____ Phone: _____ Employer: _____ Date of Birth:_____			

320 E. Central Ave. Decatur, IL 62523 | Phone: 217-877-9117 | Fax: 217-877-3079

Authorization to Request Release of Health Information: NEW/ RETURNING PATIENT

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Reason for Request:

☐ New Patient ☐ Returning Patient

For Office Use Only

Send Records By:

☐Mail ☐Fax ☐CD ☐Other: _____

X I authorize Crossing Healthcare to request information from:
(place an X by each place the patient has been in the past 5 years)

☐ Decatur Memorial Hospital

☐ DMH Express Care

☐ St Mary's Hospital

☐ Other Hospital _____
Name City/ State

☐ Other Hospital _____
Name City/ State

☐ Other Hospital _____
Name City/ State

☐ Dept of Corrections (requires a separate form)

X I authorize Crossing Healthcare to request information from:

☐ Family Doctor: _____
Name

_____
Address Phone Number

☐ Any Other Doctor: _____
Name

_____
Address Phone Number

☐ Any Other Doctor: _____
Name

_____
Address Phone Number

Information to be Disclosed:

X Complete Record (does not include Alcohol/Substance Abuse, HIV/STD, Mental Health or Genetic Records (see separate section below)

I **understand that the information contained in my health record may include information relating to sexually transmitted diseases, acquired or mental health services, and treatment of alcohol and/or drug abuse. I authorize the release of all such items marked below. By checking the boxes next to these items I understand that the following information will be released.**

☐ Alcohol or Substance Abuse/Use Disorder Records ☐ HIV and/or STD Testing and Results ☐ Mental Health Records ☐ Genetic Records

- I understand that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. The provider/CIOXX has notified me of the risks and will not be held liable if I choose to have my records sent by email.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the facility at which this request is received. Revocation will not apply to information that has already been disclosed in response to this authorization.
- I have a right to inspect and copy the health information disclosed as a result of the delivery of this authorization
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____ If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- Any disclosure of information carries with it the potential for re-disclosure, and the information may no longer be protected by federal confidentiality rules.
- If any, Consequences of Failure to consent: _____

_____ _____
Patient or Authorized Representative Signature (12 years and over) Date

_____ _____
Signature of Parent or Guardian and Relationship (if applicable) Date

_____ _____
Witness Signature required to release Mental Health Records Date

_____ _____
Employee Signature Date

Orig: 5/2022