Colleen Bingham, M.D.
P.O. Box 665 • Effingham, IL 62401

Date of Application _____

Have you applied here before? ☐ Yes ☐ No

Previously seen by: ☐ Dr. M. Brummer ☐ Dr. J. Brummer ☐ Dr. Bingham ☐ Dr. Heischmidt ☐ Dr. Crowell ☐ Dr. Bierman

Who is Applying? (check all that apply): ☐ Self (Guarantor) ☐ Spouse/Partner ☐ Children

Guarantor's Full Name: _____ Gender: _____ DOB: _____
(Responsible Party) LAST FIRST MIDDLE

Previous/Maiden Name: _____ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Address: _____ City: _____ St.: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Social Security No.: _____ Driver's License No.: _____

Race: ☐ White ☐ Asian ☐ Native Hawaiian ☐ African American ☐ Hispanic
☐ American Indian or Alaskan Native ☐ Other Pacific Islander Other Race

Ethnicity: ☐ Hispanic ☐ Non Hispanic Translator Needed? ☐ Yes ☐ No

Employer: _____ Phone No.: _____ Ext.: _____

Address: _____ City: _____ St.: _____ Zip: _____

Occupation: _____

Spouse/Partner Full Name: _____ Gender: _____ DOB: _____
LAST FIRST MIDDLE

Previous/Maiden Name: _____ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Address: _____ City: _____ St.: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Social Security No.: _____ Driver's License No.: _____

Race: ☐ White ☐ Asian ☐ Native Hawaiian ☐ African American ☐ Hispanic
☐ American Indian or Alaskan Native ☐ Other Pacific Islander ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Non Hispanic Translator Needed? ☐ Yes ☐ No

Employer: _____ Phone No.: _____ Ext.: _____

Address: _____ City: _____ St.: _____ Zip: _____

Occupation: _____

Children: _____ DOB: _____ Soc. Sec. No.: _____ Sex: ___ Race: _____
FULL NAME or expected due date

_____ DOB: _____ Soc. Sec. No.: _____ Sex: ___ Race: _____

_____ DOB: _____ Soc. Sec. No.: _____ Sex: ___ Race: _____

_____ DOB: _____ Soc. Sec. No.: _____ Sex: ___ Race: _____

PLEASE CONTINUE ON BACK:

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In case of emergency, contact (Other than spouse): _____

Address: _____ City: _____ St.: _____ Zip: _____

Relationship: _____ Phone No.: _____ Ext: _____

Current Physician _____

Primary Insurance Coverage	**Secondary Insurance Coverage**
Carrier Name & Address: _____	Carrier Name & Address: _____
_____	_____
Group No.: _____	Group No.: _____
Identification No.: _____	Identification No.: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber's Birthdate: _____	Subscriber's Birthdate: _____
Subscriber's SS#: _____	Subscriber's SS#: _____
Effective Date: _____	Effective Date _____

Are you covered by Medicaid? ☐ Yes ☐ No ID# _____

Are you covered by Medicare? ☐ Yes ☐ No ID# _____

○ **Please provide a front and back copy of all insurance cards, including Medicare and/or Medicaid.**

○ **Please provide a copy of your current driver's license or other photo ID.**

We require payment, and/or co-payment, the day of service for all office visits.

We ask all patients to show their insurance membership card so that we may copy them. Medicaid Card must be presented at each visit or payment is due the day of service. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections for insurance companies and will credit such collection to the patient's account.
I give my consent to **Family Care Associates of Effingham, S.C.** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of my family members. I have been informed and understand that I am personally responsible for the full payment of my account. In the event my account is past due more than 60 days, a finance charge will be assessed. If I have not made arrangements for payments after 90 days, I will be responsible for all fees incurred for collection and/or attorney fees.

Family Care Associates is a medical home dedicated to the comprehensive healthcare of the patients we serve. We are not a walk-in clinic. When you complete and sign your application, you agree to medical care fully managed by your new physician at Family Care Associates. Upon acceptance, previous medical records may be transferred to Family Care Associates. Complete our "Authorization for Release of Confidential Health Information" form directing records to Family Care Associates, or contact your former physician's office and request your records transferred. Thank you!

○ Signature: _____ Date: _____

How did you hear about us? ☐ Radio ☐ Newspaper ☐ Friend ☐ Health Fair ☐ Website ☐ Other

Referred By: _____

Family Care Associates

Application for Medical Care

Please bring all of your current medications (in their BOTTLES) with you to your first appointment. If you are unsure of your medical history, please contact your previous physician and request a records transfer to Family Care Associates. If you need additional space, please use the back of this sheet. Thank you!

Name of Applicant _____

Date of your last **Mammogram**? _____

Date of your last **Colorectal Screening**? _____
(Includes Hemoccult, Colonoscopy, Flex Sigmoidoscopy)

Please list your **current medications** (including over-the-counter):

_____
_____
_____
_____
_____
_____

Please list any additional medications you have taken in the last **12 months** (including over-the-counter):

_____
_____
_____
_____
_____
_____

Medication Allergies:

_____
_____
_____

Side Effect/Reaction:

_____
_____
_____

Pharmacy Name and Phone (so that we may call with questions) _____

Please list your past and current **health problems**:

Current:

_____
_____
_____
_____
_____
_____

Past:

_____
_____
_____
_____
_____
_____

Please list any **hospitalizations, operations, or injuries** (please *include dates*):

Condition(s):	**Date:**	**Does this require ongoing medical treatment? If so, what? When was your last treatment?:**

Which **doctors** have treated you in the past:

1. _____
2. _____
3. _____
4. _____

I hereby state all information given on this application/healthcare questionnaire to be true and correct. Once accepted as a patient, any information found to be untrue or incorrect could result in the dismissal of all individuals listed on this application.

_____ _____
Applicant Signature **Date**

Thank you for choosing Family Care Associates!