COMMUNITY MEDICAL CLINIC

CHILD - NEW PATIENT PACKET

Pennyroyal Healthcare Services, Inc DBA Community Medical Clinic
1102 S Virginia Street - Hopkinsville, KY 42240 - 270-632-6741 - 270-632-6742 (Fax)
Dental 1102 S Virginia Street Suite B - Hopkinsville, KY 42240 - 270-632-3088 - 270-632-6742 (Fax)
244 Thompsonville Lane - Oak Grove, KY 42262 - 270-632-6743 - 270-632-6744 (Fax)
1022 W Main Street - P.O. Box 151 - Princeton, KY 42445 - 270-365-0227 - 270-365-2559 (Fax)

Community Medical Clinic: (*Child Intake Form*)

In order to help the check in process, please fill in ALL information.

PART A:

PARENTAL / GUARDIANSHIP INFORMATION

Are you the child's biological or adoptive parent? **Circle one:** Yes No

_____ _____

Print Parent's Name ***Date***

NOTE: If you are not the child's biological or adoptive parent, you must provide legal documentation of guardianship.

PATIENT INFORMATION

_____ , _____, _____

Last Name ***First Name*** ***Middle Name***

What name would the child want to go by? _____

Circle Gender: M / F SSN: _____ - _____ -_____ Date of Birth: _____

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Middle Eastern/North African ☐ Other

Ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino Other: _____

Address: _____ **Zip Code**: _____

Home Phone: (___) _____ **Cellular:** (___) _____**Work**: (____) _____

Email Address: _____**Preferred Communication**: ☐ Phone ☐ Text

Preferred Pharmacy: _____**Pharmacy Phone#:** _____

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other**_____ ☐ **Interpreter Needed**

Living Situation: ☐ **Homeless** ☐ **Not Homeless** ☐ **Transitional** ☐ **Doubling Up** ☐ **On the Street** ☐ **Other** ☐ **Unknown**

Agricultural Worker: ☐ **Migrant** ☐ **Seasonal** ☐ **Not an Agricultural Worker**

Is the parent or guardian a U.S. Veteran? ☐ **Yes** ☐ **No**

Who is / was the child's last primary care provider? _____
Reason for Transfer of Care? _____

How were you referred to Community Medical Clinic?

_____

IN CASE OF EMERGENCY

Contact (name): _____Phone:_____
Address:_____Relation:_____

INSURANCE INFORMATION

Primary Insurance: _____ ID#_____ Group#_____
Subscriber's Name:_____ DOB:_____ Social Security #_____
Secondary Insurance:_____ ID#_____ Group#_____
Subscriber's Name:_____ DOB:_____Social Security#_____

Subscriber Address (if different than the patient): _____
_____

RESPONSIBLE PARTY INFORMATION

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired
☐ Active Military ☐ Unknown

Responsible Party Name: _____Responsible Party DOB: _____

Responsible Party Address: _____Resp. Party SSN:_____

Are you seeking treatment that is related to Workers' Compensation or an Auto Accident Injury? ☐ **yes** ☐ **no**

_____

HOUSEHOLD INCOME INFORMATION

Note: ***As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below.*** **This information is only used to obtain the grants we use to help those who do not have insurance and will not affect you in any adverse way.**

What is your annual household income?_____ How many people are in your household?_____

☐ No Income ☐ Less than 24,999 ☐ 25, 000 to 39,999 ☐ 40,000 to 59,999 ☐ 60,000 to 99,999

☐ 100,000 or more

If you are interested to know more about our Sliding Fee Scale Program, please fill out the enclosed Sliding Fee Scale discount program section below.

A sliding scale discount program is available for our uninsured and under-insured patients who may have difficulty paying.

Pennyroyal Healthcare Services, Inc.

2025 Sliding Fee Schedule Medical and Behavioral Health
(Based on 2025 DHHS Federal Poverty Guidelines)
Effective February 2025

Poverty Level	Class A FPI 100% or below	Class B FPI 101%-125%	Class C FPI 126%-150%	Class D FPI 151%-200	Class E FPI > 200%
	Discount				
Family Size	$20	75%	50%	25%	0%
1	$15,650	$19,563	$23,475	$31,300	$ 30,121
2	$21,150	$26,438	$31,725	$42,300	$ 40,881
3	$26,650	$33,313	$39,975	$53,300	$ 51,641
4	$32,150	$40,188	$48,225	$64,300	$ 62,401
5	$37,650	$47,063	$56,475	$75,300	$ 73,161
6	$43,150	$53,938	$64,725	$86,300	$ 83,921
7	$48,650	$60,813	$72,975	$97,300	$ 94,681
8	$54,150	$67,688	$81,225	$108,300	$ 105,441
For each additional person, add	$6,330				

□ Yes, I am interested in information regarding the sliding scale program.

□ No, I am not interested at this time in the sliding scale program and I do not wish to disclose my income.

Signature: _____

Date: _____

*Patient Name:*_____ *Date of Birth:*_____

Required Information and Acknowledgments

Please review each section, check each box, and sign below.

☐ **1. Release of Medical Records**

I authorize Community Medical Clinic (CMC) to release my medical records, if needed, for referral to a specialist or outside provider for continuity of care. This excludes behavioral health, HIV/AIDS status, and substance abuse records unless a separate consent form is completed. CMC will refer me to my preferred provider when possible; if unavailable, a similar qualified specialist may be selected. This authorization remains valid until revoked in writing.

☐ **2. Consent for Treatment**

By seeking care at CMC, I consent to examinations and treatments deemed necessary by my provider. I understand that medical care involves risks, including possible injury or death, and acknowledge that no guarantees have been made regarding outcomes.

☐ **3. Appointment Scheduling & Cancellation**

I agree to schedule appointments for my care and will notify the clinic at least 24 hours in advance if I need to cancel.

☐ **4. No Call / No Show**

I understand that missing three (3) appointments within 12 months without notice may result in discharge from the practice.

☐ **5. Transportation Assistance**

I understand that if I have difficulty getting to an appointment, I may notify CMC, and transportation assistance may be available.

☐ **6. Notice of Privacy Practices**

I have received a copy of CMC's Notice of Privacy Practices.

☐ **7. Payment Responsibility**

I understand that co-pays, co-insurance, and sliding scale fees are due at the time of service.

_____ Date:_____

Signature (Patient / Parent / Guardian / Legal Representative)

PART B

CHILD: NEW PATIENT HISTORY

Current problems / Concerns: _____

A. Birth History:

Was this child? ☐ Full term (greater than 36 weeks) ☐ Pre-term (less than 37 weeks)

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? ☐ Vaginal ☐ C-Section If C-Section, why? _____

Birth weight? _____ was the baby breech? ☐ yes ☐ no

Were there any problems during the newborn period? ☐ yes ☐ no Was the baby in NICU? ☐ yes ☐ no

If yes, please explain: _____

B. PAST MEDICAL HISTORY:

Has the child ever been seen by a medical specialist? ☐ **yes** ☐ **no**
If so, what type of specialist was needed? _____ **has the child ever been treated for any of the following? Check 'yes' or 'no' for each option.**

Condition	Y	N	Condition	Y	N
Allergies			**Ear Infections**		
Asthma			**Chicken Pox**		
Eczema			**Urinary Tract Infection**		
Seizures			**Acne**		
Heart Murmur			**Serious Injury or Concussion**		
Wheezing			**Developmental and/or Speech problems**		
Pneumonia			**ADHD/ADD**		

Please list any medications that the child routinely takes.

Any recent Emergency Room or Urgent Care visits? ☐ **yes** ☐ **no** **If yes, please explain:** _____

_____

This Question is For Girls Only:

Has she started her menstrual cycle? ☐ Yes ☐ no If yes, at what age? _____

FAMILY HISTORY:

Does the child or any family members have any of the following conditions? *(grandparents, parents, aunt, uncle, brother, or sister)*

Condition	Y	N	Family Member	Condition	Y	N	Family Member
Heart Attack				Migraines			
High Blood Pressure				Seizures			
Congestive Heart Failure				Melanoma (skin cancer)			
Rheumatic Heart Disease				Ovarian Cancer			
Congenital Heart Disease				Pancreatic Cancer			
Breast Cancer				Any other Cancer			
Colon Cancer				Tuberculosis			
Colitis				Diabetes			
Crohn's Disease				Goiter / Thyroid Disorder			
Colon Polyps				Blood Clotting Disorders			
Hepatitis				Bleeding Tendency			
Stomach Ulcer				Anxiety and/or Depression			
Kidney Disease				Suicide			
Stroke				Mental Illness			
Leukemia				Drug or Alcohol Abuse			

SOCIAL HISTORY:

Who lives in your child's home? _____

_____

Is your child in: ☐ Daycare ☐ School ☐ Neither If in school, what grade? _____

Does anyone in your house smoke? ☐ yes ☐ no

Do you have any concerns regarding the child's school / daycare performance? ☐ yes ☐ no

Do you have any special concerns regarding your child or is there anything more you would like to tell us about your child?

_____

_____