Patient Information:

First Name:_____ **MI**____ **Last Name:**_____ **Social Security #:**____-____-____

Date of Birth:____/____/____ **Age:**_____ **Male / Female** **Married** **Single** **Widowed** **Partnered** **Other**

Address:_____ **City:**_____ **State**_____ **Zip**_____

Home Phone:_____ **Work:**_____ **Cell:**_____

Email:_____ **Employer:**_____

Ethnicity: (circle one) **Hispanic** **Non-Hispanic** **Not Specified** **Preferred Language:**_____
Race: (circle one) **African American** **Caucasian** **Native American** **Pacific Islander** **Other:**_____

Parent or Guardian Information: (For Pediatric Patients Only)

First Name:_____ **MI**____ **Last Name:**_____ **Date of Birth:**____/____/____

Address:_____ **City:**_____ **State**_____ **Zip**_____

Home Phone:_____ **Work:**_____ **Cell:**_____

Name of Employer:_____ **Employer Address:**_____

Name of person paying this bill:_____

Insurance Information:

Name of Primary Insurance:_____ **ID#:**_____ **Group#:**_____

Name of Main Policy Holder: **Self** **Parent/Guardian** **Other:**_____ **Date of Birth:**____/____/____

Secondary Insurance_____ **ID#:**_____ **Group#:**_____

Emergency Information:

First Name:_____ **Last Name:**_____ **Phone#:**_____

Address:_____ **City/State/Zip:**_____

Mt. Shuksan Family Medicine & Dermatology keeps a record of the services provided to you. You may ask to see a copy of your record at any time. You have the right to correct that record, if necessary. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to. If you would like to view your record or have any questions pertaining to your record, please contact the administrator at (360) 647-1900.

By signing below, I acknowledge receipt of the Notice of Privacy Practices for MSFM.

X_____ Date_____
Patient Signature or Legally Authorized Individual

_____ _____
Printed name, if signed on behalf of Patient Relationship to Patient

We would like to know the best way to contact you for future lab results, correspondence, etc. Please indicate the very best way to reach you and CHECK THE BOX if we are allowed to leave confidential health information at that number.

☐ Home #_____ ☐ Cell #_____

☐ Work #_____ ☐ Other #_____

Email: _____

(Please note- Our system automatically sends appointment reminds for you scheduled appointment by email. Please notify us if you do not want this reminder.)

Please let us know if we should NOT contact you using one of the above methods of communication OR if we are not to leave a message on any of the above numbers

This form will be kept in your medical record. Last updated 6/23/2016

Patient Financial Policy

for Mt. Shuksan Family Medicine and Dermatology

We uphold our end of your care, we expect you to do the same. The following is our updated financial policy, last updated 2/5/16. *Please review this carefully.*

- You are responsible for having your current insurance card and co-payment at every visit.

- The patients insurance company will be billed if the correct information is given, and insurance payments are current; if insurance is not valid at the time of medical services provided, the patient is responsible for cash payments. The patient will authorize payment from their insurance company directly to Mt. Shuksan Family Medicine (MSFM). The person responsible for payment agrees that all services not covered under insurance payment will become their responsibility to pay to MSFM. Payments not received within 30 days of invoice, will be delinquent and you will be contacted by our billing department for payment in full.

- MSFM will promptly process and bill your medical services through insurance. We expect you to promptly pay your portion of your bill. If we have to send out more than 1 statement for patient remaining balances unpaid, we will add a service charge of $5.00 for every additional statement we send out, until full payment is received. To avoid additional fees, please promptly pay your bill from us by calling our billing department to arrange a payment schedule at (360) 734-3378.

- Accounts that are past due with no response to billed invoices must call our billing department to coordinate payments ASAP, otherwise the patient may be terminated from the practice, and may suffer financial penalties and/or be sent to collections.
- No show appointments will be charged $40. After 3 no show appointments and/or late cancellations (with less than a full 24hrs notice given to our clinic), you will be asked to leave the practice. We have many patients waiting to be seen, and missed appointments take up valuable time.

- Cash paying patients will need to pay in full for all services provided on the date of service, no exceptions.

- NSF checks and returned funds, will be charged $35 and need to be paid in full with cash or card prior to further medical appointments or care.

- Mt. Shuksan Family Medicine reserves the right to change the terms/fees without notice.

By signing below I certify:

- that the personal information I provided is true and correct.
- that I have read, understand and agree with the financial policies and terms outlined above. I understand it is a crime to falsify information or withhold necessary information, and is punishable by law.
- I have also read or been given a copy of the PRIVACY POLICY and understand and accept it.

_____

Signature

_____ _____

Printed legal name Date

Name:_____ Date of Birth:___/___/_____ Today's Date: ___/___/_____

Reason for Today's Visit?_____

Past Medical Problems:_____

Surgeries and Hospitalizations:_____

ALLERGIES to medications/foods/other:_____

What Reaction? _____

Daily Medications AND Vitamins/Supplements- DOSE

Last Physical Exam_____
Pap Smear_____
Mammogram_____
DEXA Bone Scan_____
Colonoscopy_____
ECG Heart Test_____
Immunizations
Tetanus_____
HPV_____
Hepatitis
A/B_____
Tuberculosis_____
Pneumonia_____
Zostavax_____
Other_____

General: Fatigue, hair loss, change in appetite, weight issues
Ears, Nose and Throat:
Vision or Hearing change
Dental concerns
Itching/Watery eyes
Sinus Problems
Heart: Chest Pain or Tightness
Irregular Heart Rate
Swelling in the Ankles
Leg Pain when Walking
Respiratory: Cough, breathing problems, wheezing
Skin: Rashes, Dry Skin, Itching, Concerning Bumps/Moles
Problems Healing

Gastrointestinal: Stomach Pain, Heartburn, Nausea or Vomiting, Diarrhea, Constipation, Bloating, Blood in Stool, Rectal Pain/Itching
Genitourinary: Incontinence, Change in Bladder Habits, Pain with Urination/Ejaculation, Sexual Dysfunction/Problems
Emotional Health: Anxiety, Insomnia, Depression, Headaches, Racing Thoughts, Poor Focus
Other:_____

Women Column Only:
Last Menstrual Period:_____
Age at First Period: _____
# of Pregnancies:_____
# of Births:_____

Concerns with:
Hot Flashes, Night Sweats, Mood Swings, Irregular Periods,
Painful Periods, Contraception, Painful Intercourse, Discharge, Family Planning Concerns

Family History:
Please List Conditions

Mother:_____

If deceased, age at death:_____

Father:_____

If deceased, age at death:_____

# of Siblings: _____
Please List Health Problems

Mother's Parents
GM:_____
GF:_____
Dad's Parents
GM:_____
GF:_____

Please Circle All That Apply For Relatives:

Diabetes, Heart Trouble/Heart Attack, Stroke, High Blood Pressure, Aneurysm, Arthritis, Thyroid Disorders, Cholesterol, Osteoporosis, Depression, Mental Illness, Suicide

Cancers: Breast, Ovarian, Prostate, Colon, Stomach, Melanoma (Skin), Thyroid, Bone
Other Cancers/Illnesses:_____

Occupation:_____ How did you hear about us?_____

Use of Alcohol: Never Daily Quit (when?)_____ Current Amount Per Week?_____
Use of Tobacco: Never Daily Quit (when?)_____ Current Amount Per Week?_____
Use of Drugs: Never Daily Quit (when?)_____ Current Amount Per Week?_____

Exercise: Never No Regular Regimen Yes (What type and How Often?)_____

Diet Habits: Balanced Meals Vegetarian/Vegan Diet High in: Fat Carbohydrates Protein

Are You Currently Dieting? Yes No

How often per week do you eat out?_____ Use of Soda/Juice per day?_____

Are you content with your current weight? Yes No