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:

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 Other than your own:________________________ 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?______________________

List Past Medical Problems:______________________

Surgeries and Hospitalizations:______________________

Allergies to medications/foods/other______________________

Daily Medications and Supplements/Vitamins:______________________

Fluoride?______________________

Multivitamins?______________________

Dental exams: last exam__________ Exams every: 6 mo 12 mo

siblings:______________________

How did you hear about us?______________________

Weeks Gestation__________

Healthy Pregnancy?__________

Birth Place__________

Birth weight__________

Breast fed, how long?________

Formula fed, type/how much?

Exposure to second hand smoke?

Yes No

Prior primary care provider____

Last Well Child exam________

<u>Immunizations</u> (please circle those given and provide the nurse with a copy of immunization history)

Tdap Hib IPV/OPV

MMR Pneumococcal (PCV)

Hepatitis A/Hepatitis B

RotoVirus Varicella

Influenza HPV

Meningococcal (MCV)

<u>Symptoms/Concerns:</u>

<u>General</u>: Fussiness, fever, fatigue, change to appetite, weight issues/changes

<u>Ears, Nose and Throat</u>: Vision or Hearing concerns, Dental concerns, Itching/watery eyes, Sinus problems, Pulling at ears

<u>Heart</u>: Chest pain, Irregular heart rate, Shortness of breath, Swelling in the ankles

<u>Respiratory</u>: cough, wheezing Breathing problems

<u>Skin</u>: Rashes, dry skin, itching, Diaper rash, Moles

<u>Gastrointestinal</u>: stomach pains, Nausea or vomiting, diarrhea, Constipation, blood in stool, Rectal pain/itching

<u>Genitourinary</u>: Change in bladder habits, Change in urine color/smell, Pain with urination

<u>Emotional Health</u>: Anxiety, agitation insomnia, depression, headaches, racing thoughts, poor focus

Other:______________________

<u>Family History</u>: Please List Conditions

Mother:______________________

if deceased, age at death_______

Father:______________________

if deceased, age at death_______

# of Siblings:_____ List health problems:

<u>Mother's Parents:</u> GM:______________________

GF:______________________

<u>Dad's Parents</u>: GM:______________________

GF:______________________

<u>Please circle all that apply for relatives</u>:
Diabetes, heart trouble/heart attack, stroke, high blood pressure, aneurysm, arthritis, thyroid disorders, cholesterol, osteoporosis depression, mental illness, suicide

<u>Cancers</u>: Breast, ovarian, prostate, colon, stomach, melanoma (skin), thyroid, bone.

Other Cancers/Illnesses:______________________

School______________________

<u>Diet Habits</u>: Balanced meals Vegetarian/Vegan High in: Fat Carbohydrates Protein How often per week do you eat out? ________

Use of soda/juice per day? ________ Are there current weight concerns? Yes No

<u>Daily Screen Time</u>(computer/TV): None <2hrs/day >2hrs/day <u>Exercise</u>: None 30min-2hrs/day other__________

<u>Beliefs</u>: effecting medical care decisions? How?______________________

<u>Use of alcohol/tobacco/recreational drugs</u>: which? How long?______________________

Reviewed by:______________