Bridge City Family Medical Clinic

Phone (503)-460-0405 1410 NE 106th Ave., Portland, OR 97220 Fax (503)-460-0430

Adolescent Health & Social History
(13-17 years of age)

Patient Name: _____ Date of Birth: _____

Parent's Name: _____ Sex: ☐ Male ☐ Female

Are there any medications taken regularly? ☐ Yes ☐ No
If yes, check those which apply:
☐ Fluoride ☐ Vitamins ☐ Aspirin ☐ Tylenol ☐ Cold Medicine ☐ Other _____

Any known allergies to drugs or medicines? ☐ Yes ☐ No **If yes**, please list: _____

Is teen up to date on all vaccinations? ☐ Yes ☐ No
If no, list reason why and what is needed _____

ADOLESCENT'S KNOWN HEALTH ISSUES *(check which apply)*

☐ Eye/Vision Problem ☐ Ear/Hearing Problem ☐ Toothache/Decay ☐ Asthma/Breathing Problem
☐ Heart Disease/Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Anemia
☐ Stomach ache ☐ Sickle Cell Anemia ☐ Diabetes ☐ Headaches
☐ Low Blood Sugar ☐ Kidney/Bladder Problem ☐ Seizures/Epilepsy ☐ Blood Transfusion
☐ Bone/Joint/Muscle Problem ☐ Accidents/Injury ☐ Vaginal Problem
☐ Penis/Scrotal/Testicular Problem ☐ History of Physical/Sexual Abuse
☐ Unusual Bruising/Bleeding Disorder ☐ Exposure to Dangerous Chemicals/Materials
☐ Other_____

ADOLESCENT'S PAST MEDICAL HISTORY

BIRTH
Birth Weight: _____ lb. _____ oz. Length: _____ in.

Vaginal or C-Section? _____

Born at: ☐ Hospital _____ ☐ Other _____

Place of Birth: City _____ State: _____ Country: _____

Was child full term? **If no**, please explain: _____

_____

Problems with pregnancy/labor/delivery? _____

Health complications since birth? _____

SURGERY
Has teen had any surgeries since birth? ☐ Yes ☐ No
If yes, describe reason for surgery, location, any complications, and length of hospital stay: _____

_____

Please describe any concerns that you have today: _____

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FAMILY HISTORY *(check which apply)*

	Adolescent's Mother (Mother's Side)	Adolescent's Father (Father's Side)	Adolescent's Siblings	Adolescent's Grandparents	Adolescent's Grandparents
Alcoholism	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Use/Abuse	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐
Hepatitis (A, B, C)	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

Other Family Medical Concerns: _____

_____

ADOLESCENT'S PARENTS *(check which apply)*

Mother:
Living _____ Deceased _____
If deceased, age and reason: _____

Father:
Living _____ Deceased _____
If deceased, age and reason: _____

ADOLESCENT'S HISTORY

GENERAL

Who lives in the household with the teen (list relationship to teen and age of person living with) _____
_____

What language(s) spoken within the home? _____

What school does the teen attend? _____

Are there any pets in the household? ☐ Yes ☐ No

Is there any smoking inside the teen's house? ☐ Yes ☐ No
Does anyone smoke outside? ☐ Yes ☐ No

How many hours of television and/or video games does your child watch each day? (Circle which applies)
30 minutes or less 1-2 hours more than 2 hours

In one week, on how many days does your child usually play actively/exercise for at least 30 minutes? (Circle which applies)
0-2 days 3-5 days 6-7 days

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How many cups of soda, fruit drinks, sports drinks, or juice does your teen usually drink in one day? _____
Are you ever concerned about your teen's safety in your home? _____
Are you concerned your teen may have been physically, emotionally, or sexually abused in his/her life? _____
_____
Has your teen had a change in appetite, eating habits, or energy level? _____

RESPIRATORY
Has your teen ever had wheezing, asthma, or coughed up blood? _____
Does your teen snore loudly or have trouble breathing while sleeping? _____
Does your teen frequently cough while running or playing? _____

NEUROLOGICAL
Has your teen ever had seizures, memory loss, or unexplained trembling or dizziness? _____
Any concerns with the way your teen learns, walks, or talks? _____

CARDIAC
Have you ever been told your teen has a heart murmur? _____
Has your teen ever had chest pain, "racing heart", or shortness of breath during regular daily activities? __ _____
_____

GASTROINTESTINAL
Does your teen have problems with frequent diarrhea or constipation? _____
Does your teen frequently complain of stomachaches? _____

URINARY
Has your teen ever had trouble urinating? Frequent or painful urination? _____
For girls—any concern with menstrual cycle? _____

HEENT (head, ears, eyes, nose, throat)
Has your teen had a change in vision or hearing? _____
Has your teen had an eye exam in the last year? _____
Does your teen get frequent headaches or sinus congestion? _____

SKIN
Has your teen had problems with rashes, acne, warts, or moles? _____

BONES
Has your teen broken any bones in the past? If yes, which bone and date occurred? _____
Has your teen ever had bone or joint swelling? _____

NECK
Has your teenever had swollen glands, pain or stiffness? _____

MOOD
To your knowledge, does your teen have any school or family problems troubling him/her? _____
_____
Does your teen ever seem depressed, anxious, or talk about death or suicide? _____
Has your teen ever been in counseling or been treated by a mental health professional? _____

DENTAL
When was the last time your teen saw a dentist? _____
Have you noticed brown or white spots on your teen's teeth? _____
Has your teen ever complained of tooth aches/pains? _____

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CONCERNS TO BE DISCUSSED WITH PROVIDER

- ☐ Physical Problems
- ☐ Weight/Nutrition
- ☐ Sleep Patterns
- ☐ Relationship with Family
- ☐ Moodiness
- ☐ Violence/Gangs
- ☐ School Problems/Absence
- ☐ Smoking, Drug/Alcohol Abuse
- ☐ Dating/Parties
- ☐ Sexual Behaviors
- ☐ Pregnancy/STI's
- ☐ Sexual Identity
- ☐ Other _____

PATIENT/PARENT/GUARDIAN CONSENT

I authorize release of any information necessary to process my medical insurance claim. I authorize benefits payable directly to Bridge City Family Medical Clinic, PC.

_____ _____

Print Teen Name Date Signature of Parent/Guardian Date

_____ _____

Relationship to Teen Date Provider Signature Date

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Consent for Release of Protected Health Information

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize and give my permission to the providers/individuals listed below to release and/or receive a copy of my record
(Circle which apply)

To Bridge City Family Medical Clinic FROM THE PARTY NAMED BELOW	From Bridge City Medical Clinic TO THE PARTY NAMED BELOW	To verbally exchange with THE PARTY NAMED BELOW

MEDICAL FACILITY/INDIVIDUAL RECORDS MAY BE SHARED WITH

Name Individual records will be coming from or sent to (Provider, Doctor, Attorney) _____

Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

RECORD DELIVERY METHOD (*circle which apply*)

MAIL FAX PICK UP DATE: _____

PURPOSE FOR THIS DISCLOSURE (*circle which apply*)

Medical Care Legal Eligibility Determination Client Request Other

By **INITIALING BELOW**, I GIVE MY PERMISSION TO RELEASE: All records from all dates seen by Provider/Clinic.

Physician Reports _____ Radiology Reports _____ Exam Forms _____

Medical Log _____ Immunization Records _____ Laboratory Reports _____ Other _____

Release of the following records & information requires specific authorization: By initialing the spaces below, I specifically authorize the voluntary release of the following medical records, if such records exist. I understand they are protected by Federal & State Law (ORS 433.045(3), OAR 33312270(8)(a), ORS 659.7100). I also understand that I may revoke this authorization at any time to the extent that information has already been released based upon this authorization.

HIV/AIDS _____ Sexually Transmitted Infection Info. _____ Mental Health Record _____

Genetic Information _____ Drug/Alcohol Records _____

PATIENT CONSENT

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent. In Oregon, unless revoked earlier, this consent will expire in 120 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request. I understand that by not signing this, I will still be able to receive medical care from Bridge City Family Medical Clinic.

Patient/Guardian Signature _____ Date _____

The information disclosed to you by this authorization is protected by state law (ORS 179.505.192.525) & Federal regulations (42 CFR Part 2, 45 CFD Parts 160-164). You are instructed that you may not further disclose this information without the written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol/drug treatment records. Federal rules restrict the use of alcohol/drug treatment records to criminally investigate or prosecute any alcohol/drug abuse patient.

These records are being requested for continuity of use. We are requesting this as a medical courtesy and do not offer reimbursement.

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Adolescent New Patient (13-17 years of age)

Please Complete ALL Questions ~ We Require ALL Information to be Filled in

PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Check Which Applies				
				Male	Female	FTM	MTF	Other
			/ /					

Address	City	State	Zip

Home Phone #	Cell Phone #	Marital Status - Check Which Applies				
		Married	Single	Divorced	Widowed	Dom. Partner

Employer	Employer Address City State Zip	Driver's License #

Emergency Contact Name	Emergency Contact Phone #

RESPONSIBLE PARTY (PARENT/GUARDIAN INFORMATION)

Last Name	First Name	M.I.	Date of Birth	Social Security #
			/ /	

Address	City	State	Zip

Home Phone #	Cell Phone #	Work Phone #

INSURANCE INFORMATION

Primary Insurance Company	Insurance Address	State	Zip

Member ID #	Group #	Plan #

Insurance Phone #	Insurance Coverage Type - Check Which Applies				
	EFO	PPO	POS	HMO	

Subscriber/Patient Relationship - Circle Which Applies

Self Spouse Child Other

Secondary Insurance Company	Insurance Address	State	Zip

Member ID #	Group #	Plan #

Insurance Phone #	Insurance Coverage Type - Check Which Applies				
	EFO	PPO	POS	HMO	

Subscriber/Patient Relationship - Circle Which Applies

Self Spouse Child Other

I hereby authorize *Bridge City Family Medical Clinic* to furnish information to insurance concerning my illness and treatment and to imitate a complaint to the Oregon Insurance Commissioner on my behalf, if and when necessary. Assign any and all insurance benefits for treatment to *Bridge City Family Medical Clinic*. Acknowledge that I am ultimately responsible for any prior authorization or referral required by my insurance company. Assume complete financial responsibility for costs denied or rejected and for services not covered by my insurance company. Understand that any account sent to outside collections will be charged a $40.00 Collection Fee which I am responsible to pay.

_____ _____

Patient/Guardian Signature Date

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Adolescent Self Questionnaire (13-17 years of age)
(Completed by adolescent patient)

Name: _____ Date of Birth: _____Sex: Male ☐ Female ☐ M to F ☐ F to M ☐

Best way to reach you? (telephone number, email address) _____

ADOLESCENT'S HISTORY

In general would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check if you have any questions, concerns, or would like to discuss any of the following with your provider:

☐ Height/Weight	☐ Mouth/Teeth/Breath	☐ Trouble sleeping/feeling tired	☐ Sad or crying often
☐ Skin rashes or Acne	☐ Painful of Frequent Urination	☐ Nutrition or Exercise	☐ Stomach Problems
☐ Periods	☐ Body Changes	☐ Wet Dreams	☐ Headaches
☐ Eye, Nose, or Ear Problems	☐ Breasts	☐ Muscle/Joint Problems	☐ Stress
☐ Discharge from Penis/Vagina	☐ Not getting along with family	☐ Physical/Sexual Abuse	☐ Death/Dying

What school do you attend? _____
How is school going for you? Excellent Good Just OK Not Very Good
How are things at home? Excellent Good Just OK Not Very Good

Who lives in the home with you? _____

What do you like to do for fun? _____

When you ride in a car, do you wear a seatbelt? ☐ Yes ☐ No
Do you have any concerns about the size or shape of your body? ☐ Yes ☐ No
Have you ever taken any medication (pills) or other things (steroids) to change something about your body? ☐ Yes ☐ No
Have you ever smoked cigarettes or used tobacco? ☐ Yes ☐ No
If yes, are you still smoking/using and how much/often per week? _____
Have you ever smoked marijuana? ☐ Yes ☐ No
Have you used any other drug? ☐ Yes ☐ No
Do you ever drink beer, wine, or alcohol? If yes, which and how many times per week? _____

Have you ever ridden in the car with someone who has been smoking marijuana, using drugs, or drinking? ☐ Yes ☐ No
Does anyone in your family drink or take drugs so often that it worries you? ☐ Yes ☐ No
Has anyone ever touched you in a way that you didn't want or made you uncomfortable? ☐ Yes ☐ No

Have you ever had sexual intercourse, given or received oral sex? ☐ Yes ☐ No

Have you ever been pregnant or gotten someone pregnant? ☐ Yes ☐ No
Have you ever pierced your body (other than the ears) or gotten a tattoo? ☐ Yes ☐ No

Have you ever been in a relationship with someone who pushed, hit, threatened, or yelled at you? ☐ Yes ☐ No
Compared to other people, do you think you feel more sad, depressed, or angry at times? ☐ Yes ☐ No
Have you ever seriously thought about hurting or killing yourself? ☐ Yes ☐ No

Have you started your period? ☐ Yes ☐ No
Have your periods skipped months before or seemed irregular? ☐ Yes ☐ No
How many days does your period typically last? _____ When was your last period? _____
Do you have any troubles with your periods (cramps, back pain, breast tenderness)? ☐ Yes ☐ No

What are some of your concerns, worries, or questions that you would like to discuss with your provider? _____

_____

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Patient Responsibilities

Patient Responsibility: Patients are responsible for all charges resulting from treatment *by Bridge City Family Medical Clinic(BCFMC)*. As a courtesy to you, we will bill most insurance companies directly; however you are responsible for your account. Payment is due within thirty (30) days of receiving your bill, unless other payment arrangements are made. If your account goes to collection, you will be responsible for all fees incurred. *Patients are responsible for knowing what their insurance will and will not cover*.

Initial Visit: At your first visit you must have your current insurance card(s) and photo ID. You will be expected to pay for your visit if you do not have your current insurance information. You mayalso need to pay cash at the time of service if you have a co-pay, un-met deductible or are being seen for a non-covered service. Patients who do not need to pay at time of service are those with *HMO/PPO* insurance (except for the co-pay), *Medicaid* and *Medicare* insurance, OHP members with the correct doctor (PCP), and MVA appointments.

Insurance: Patients must bring their current insurance cards to each appointment. Your insurance policy is a contract **betweenyou and your insurance company**. We are not a party to that contract. Consequently, you are responsible for co-pays, co-insurance, deductibles, non-covered services, and items considered "not medically necessary to treat" by your insurance company. These are due at the time of service. If payment cannot be made at each visit, notify the business office to make other arrangements.***We will bill your insurance for you. Providing correct insurance information is the responsibility of the patient/guarantor.***Any remaining balance should be paid off within one (1) month of notice from the insurance company. If you or your insurance company makes a payment that exceeds your balance, reimbursement will be made.

HMO/PPO Plans: Co-payments are due at each visit. You will not receive a monthly statement unless there is a balance owing from the patient.

Oregon Health Plan: It is your responsibility to bring your current insurance card with you to each visit. If you do not, you may be asked to reschedule your appointment if we cannot verify coverage for that visit.

Medicare: We are Medicare Providers.

Motor Vehicle or other Liability Claims: We will bill your auto insurance or other liability insurance one (1) time as a courtesy. Settlement of these claims can take several months, full payment for the visit or financial arrangements must be made at the time of service.

Divorced Parents: BCFMC will not be responsible for disputes between parents due to a divorce. The parent who brings the child in will be responsible for the bill unless a court order is brought to the appointment showing parent responsibility for bills.

Collection Charges: The Guarantor will be responsible for the cost of collection and/or court costs and reasonable legal fees. Accounts assigned to collections will be charged a fee of *$40.00*.

Return Checks: Patients will be charged a *$25.00* return check fee for checks that are returned by the bank; any future payments must be made in cash or money order.

Abusive Behavior: Verbal or physically abusive behavior or profanity towards staff will not be tolerated. This type of behavior will result in immediate discharge from the clinic.

Social Media: If you post a negative review on a social media site such as Facebook, Yelp, Google, Twitter, CitySearch or other internet based site you may be dismissed as a patient of the clinic. We take your concerns and your privacy very seriously and we believe that posting information without first attempting to resolve the issue directly with us is harmful to the therapeutic relationship we have. We are unable to respond to your concerns via social media. If you have a complaint or a concern please contact your provider or medical assistant directly. If you feel that your complaints have still not been adequately addressed please feel free to discuss with the medical director, Dr. Teri Bunker, DNP, FNP.

Missed/Late Appointments: You are expected to arrive *10 minutes prior* to your scheduled appointment. If you arrive more than *10 minutes past* your scheduled appointment time we may need to reschedule your appointment. If we do need to reschedule your appointment due to being late or not showing up entirely, a *$25.00* charge may be billed to your account. Chronic tardiness and missed scheduled appointments may result in dismissal from the clinic.

Advanced Notice for Appointment Cancellations/Reschedules: If a cancellation or reschedule is needed for a scheduled appointment, BCFMC requires at least a one (1) day prior notice. Failure to cancel an appointment in the given time may result in a fee of $25.00 billed to your account. Chronic failure to notify staff of cancellations or reschedules in the appropriate time may result in dismissal from the clinic.

Pharmacy: We require seven days' prior notifications on all prescription refills. Refill requests made on Friday will not be available until the following Monday. ***No refills requests will be handled after hours or on weekends***.

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I have read and received a copy of the Patient Responsibilities for *Bridge City Family Medical Clinic*. I accept this policy for treatment with *Bridge City family Medical Clinic*.

_____ _____ _____

Print Patient/Guarantor Name Patient/Guarantor Signature Date

Privacy Notice Acknowledgement

To our Patients:

Federal Law requires that we provide you with a copy of our Privacy Notice.

The privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have any questions about the Privacy Notice, please feel free to direct these to Privacy Officer at any time. The name and contact number of the Privacy officer is listed on your copy of the Privacy Notice.

I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE.

_____ _____ _____

Print Patient Name Patient/Guardian Signature Date

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