Bridge City Family Medical Clinic

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

Adult Health & Social History

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

Occupation: _____ Highest Level of Education: _____

Known Drug Allergies: _____

Current Medications/Dose information: _____

_____

MEDICAL HISTORY (*check which apply*)

- ☐ Abdominal Pain – Chronic
- ☐ Accidents/Injury
- ☐ Allergies/Hay fever
- ☐ Anemia
- ☐ Appetite – Loss of
- ☐ Arthritis/ Rheumatism
- ☐ Asthma/Wheezing
- ☐ Back Pain – Recurrent
- ☐ Blood Transfusion
- ☐ Bone/Joint/Muscle Problem
- ☐ Bowel Habits – Change in
- ☐ Bronchitis/Chronic Cough
- ☐ Cancer
- ☐ Chest Pain
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Diverticulosis/Crohn's/Colitis
- ☐ Dizziness/Fainting
- ☐ Ear – Hearing Problem
- ☐ Ear Infection – Frequent
- ☐ Exposure to Dangerous
- ☐ Chemicals/Materials
- ☐ Eye Infection
- ☐ Eye/Vision Problem
- ☐ Fatigue – Chronic
- ☐ Foot Pain – Cold/Numbness
- ☐ Gallbladder Trouble
- ☐ Gout
- ☐ Hair Loss
- ☐ Headaches – Frequent
- ☐ Heart Disease/Murmur
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Physical/Sexual Abuse
- ☐ Indigestion/Heart Burn
- ☐ Jaundice/Hepatitis
- ☐ Kidney/Bladder Problem
- ☐ Lactose Intolerance
- ☐ Leg Pain – Walking
- ☐ Low Blood Sugar
- ☐ Memory Loss
- ☐ Moodiness – Excessive
- ☐ Nausea/Vomiting – Persistent
- ☐ Nervous/Depression/Anxiety
- ☐ Nose Bleeds
- ☐ Numbness/Tingling Sensations
- ☐ Osteoporosis
- ☐ Penis/Scrotal/Testicular Problem
- ☐ Phobias
- ☐ Pneumonia
- ☐ Prostate Disease
- ☐ Psoriasis/Eczema
- ☐ Rashes/Hives
- ☐ Seizures/Epilepsy
- ☐ Sexual/Menstrual Dysfunction
- ☐ Sickle Cell Anemia
- ☐ Sinus Trouble
- ☐ Stomachache
- ☐ Stools – Bloody/Tarry
- ☐ Stroke
- ☐ Throat/Trouble Swallowing
- ☐ Thyroid Disease
- ☐ Toothache/Decay
- ☐ Tremors – Hands Shaking
- ☐ Ulcers – Peptic
- ☐ Unusual Bruising/Bleeding Disorder
- ☐ Urination – Decrease in Force/Flow
- ☐ Urination – Pain/Loss of
- ☐ Control/Blood
- ☐ Vaginal Problem
- ☐ Varicose Veins/Phlebitis
- ☐ Weight Loss – Recent

☐ Other_____

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

Date of last vaccination: ☐ Tetanus _____ ☐ Flu _____ ☐ Pneumonia _____ ☐ Other _____

Hospitalization/Surgery (Date/Reason): _____

_____

Are you seeing other healthcare providers? ☐ Yes ☐ No If yes, who and why? _____

_____

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Please describe any concerns that you have today: _____

FAMILY HISTORY *(check which apply)*

	Your Mother (Mother's Side)	Your Father (Father's Side)	Your Siblings	GrandparentsGrandparents	
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	☐	☐	☐	☐	☐

YOUR PARENTS *(check which apply)*

Mother: Father:

Living _____ Deceased _____ Living _____ Deceased _____

If deceased, age and reason: _____If deceased, age and reason: _____

HABITS& LIFESTYLE

COFFEE Daily Intake: _____

SODA/JUICE Daily Intake _____

ALCOHOL Type: _____ Amount: _____

Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking habits? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking habits? ☐ Yes ☐ No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

CIGARETTES Do you smoke? ☐ Yes ☐ No If yes, what is your daily intake? _____

How long have you been smoking? _____ Are you interested in stopping? ☐ Yes ☐ No

DIET Briefly recall what you have eaten in the last 24 hours: _____

EXERCISE Do you participate in regular physical activity? ☐ Yes ☐ No If yes, what type? _____

DRUGS Do you currently use any street drugs? ☐ Yes ☐ No If yes, what type? _____

In the past? ☐ Yes ☐ No If yes, what type? _____

SLEEP ☐ Difficulty falling asleep ☐ Early morning awakening ☐ Difficulty staying asleep ☐ Daytime drowsiness

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During the past month, have you been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No
During the past month, have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

What is your relationship status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Dom. Partnership ☐ Civil Union ☐ Other: _____

What is your current living situation? ☐ Live with spouse/partner ☐ Live with roommate(s) ☐ Live alone ☐ Homeless ☐ Nursing home

Do you feel safe in your relationship? ☐ Yes ☐ No

In the past year have you been threatened, hurt, afraid, or otherwise physically abused by someone? ☐ Yes ☐ No

Do you identify as: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Queer ☐ Other: _____

May we record information about your sexual orientation and/or gender in your chart? ☐ Yes ☐ No

Are your current sexual partners men, women, or both? _____

Have you been tested for HIV/AIDS? ☐ Yes ☐ No

Are you HIV+? ☐ Yes ☐ No

THIS SECTION FOR FEMALE PATIENTS ONLY

Are you pregnant? ☐ Yes ☐ No Planning pregnancy? ☐ Yes ☐ No Are you experiencing menopause? ☐ Yes ☐ No

Number of pregnancies: _____ Abortions: _____ Miscarriages: _____ Live births: _____

Are you interested in starting a new birth control method? ☐ Yes ☐ No

Current birth control method: ☐ N/A ☐ Pills ☐ Condoms ☐ Depo ☐ IUD ☐ Diaphragm ☐ Sterilization ☐ Rhythm Method ☐ Pull Out ☐ Other: _____

Pain/Bleeding during or after sex? ☐ Yes ☐ No Date of last mammogram: _____ ☐ Normal ☐ Abnormal

First day of last period: _____ Menstrual flow: ☐ Regular ☐ Irregular ☐ Pain/Cramps

Days of flow: _____ Length of cycle: _____ Date of last pap test: _____ ☐ Normal ☐ Abnormal

THIS SECTION FOR MALE PATIENTS ONLY (*check if apply*)

Undescended testicle ☐ Testicular mass/lump ☐ Other: _____ ☐ _____

PATIENT 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.

_____ _____

Patient/Guardian Signature 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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Adult New Patient

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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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