



Dear New Patient:

Welcome to our practice! We are very pleased that you have selected us for your medical care. Enclosed are forms for you to fill out prior to your appointment to help assist our office staff and your provider in making sure that we have all the necessary information to provide you with the quality of care and treatment you deserve. Listed below are some helpful hints to make sure your visit goes as smooth as possible.

- Our providers try very hard to stay on time with their patients, but sometimes medical emergencies do occur which can cause them to run behind. You can do your part by kindly checking in 15 minutes prior to your appointment to help prevent delays.
- For your first appointment, please bring all medications, supplements, vitamins, etc. in the original bottle to your appointment so we can verify dosage and fill date so there are no discrepancies.
- Insurance cards, picture ID, and Co-pay are required at every visit.
- We offer a secure patient portal where you can view your medical history, results, send a message to your provider, and receive and pay statements online.
- If you cannot make it to your scheduled appointment, we ask that you give us at least a 24 hour notice.
- To initiate a medication refill request, please call your pharmacy and allow 24-48 business hours for the pharmacy to contact our office and then the refill process will begin.
- Our onsite lab hours are 7:30-4:00pm (closed for lunch 12:00 pm – 12:45pm)

Deer Park Family Care Clinic is committed to quality care and meeting our patients needs. We also offer visiting specialists such as cardiology, podiatry, mental health, chiropractic, and ENT services.

Once again, welcome to our practice.

Cordially,
Deer Par Family Care Clinic

Name: _____

MRN: _____

Deer Park Family Care Clinic

Main reason for today's visit:

1. _____

Other concerns I would like to discuss if there's time:

2. _____

3. _____

Please check all that apply:

___ I have prescriptions that need to be refilled: _____

___ I need a school or work excuse

___ I need a referral for my insurance company

___ I need the attached forms filled out

___ Other

Please mark in the space provided if **You** or a **Family Member** (Other) have had any of the following:

<u>You</u>	<u>Other</u>		<u>You</u>	<u>Other</u>		<u>You</u>	<u>Other</u>	
___	___	Diabetes	___	___	Heart disease or Heart Attack	___	___	Varicose veins/Wounds
___	___	Cancer	___	___	High blood pressure	___	___	Eye problems
___	___	Autoimmune Disease	___	___	Low blood pressure	___	___	Hearing problems
___	___	Thyroid problem	___	___	Stomach ulcers/Acid Reflux	___	___	Rash/Skin Disease
___	___	Bleeding or clotting disorders	___	___	Liver disease	___	___	Weight loss (>10lbs)
___	___	Anemia	___	___	Hepatitis or Jaundice	___	___	Weight gain
___	___	Asthma/COPD/Lung Disease	___	___	Kidney problems	___	___	Depression/ Mood concerns/Anxiety
___	___	Neurologic disorder	___	___	Gout	___	___	Chemical /Alcohol dependency
___	___	Stroke	___	___	Musculoskeletal disorders	___	___	Other:
___	___	Respiratory disease	___	___	Arthritis	___	___	
___	___	Artificial heart valve or artificial joint(s)	___	___	Circulatory problems	___	___	

(Please complete both sides)

Name: _____

MRN: _____

Please list all prescription and over the counter **Medications** and doses (if you have a list of your medications we can copy it for you):

Please list all **Surgeries** and any complications: _____

Please list known **Allergies** to medications or other items and your reaction to them: _____

Date/Location of last Labs: _____

Recent/Pertinent Imaging (e.g. X-ray, CT): _____

Immunizations needed? Y N

Have you seen another physician or specialist recently, and if so which physician and when?

Do you smoke? Y N _____ pack/day x _____ years

Do you drink alcohol? Y N _____ drinks/day _____ drinks/week _____ drinks/month _____ rare

Do you smoke/use marijuana? Y N _____ times/day _____ times/week _____ times/month _____ rare

How often do you exercise and what type?

Do you have concerns about your weight/dietary habits?

I certify that all the above information is true and correct to the best of my knowledge. I give my permission to physicians and staff at the Deer Park Family Care to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my medical problem.

Patient Name: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

(Please complete both sides)

Deer
Park Family
Care Clinic

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Please send records to: Deer Park Family Care Clinic
Attention: Megan M
P.O. Box 1529
Deer Park, WA 99006

Phone (509) 276-5005

Fax (509) 276-7785

Patient Information

Name: _____ DOB: ____/____/____
(Last Name) (First Name) (Middle Initial)

Phone: (____) _____ - _____ Primary Care: _____

I Authorize Deer Park Family Care Clinic (DPFCC) To:

Obtain health information from: _____
(Facility, provider, other)

Address: _____ City: _____ State: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

-OR-

Release my information **from** DPFCC **to:** _____
(Facility, provider, other)

Address: _____ City: _____ State: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

Purpose of Disclosure:

Transfer of care Moving Legal Other: _____

Information to be Released:

Last year Last 3 office visits Hospital Reports EKG's Labs X-rays
 Immunizations Recent History & Physical

Expressed Consent:

I understand that my records may contain health information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for these records to be released. I understand that once the health information is released to the recipient, the person/organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.

Patient or Legally Authorized Individual Signature

Date

Printed Name

Relationship to Patient