Deer Park Family Care Clinic

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:

You	Other		You	Other		You	Other	
__	__	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)

DPFCC New Patient

Name: _____ **DOB:** ____/____/____

SSN:_____ **Marital Status:** Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race:_____ **Ethnicity:** Hispanic ☐ Non-Hispanic ☐ **Email Address:** _____

Physical Address: _____

Mailing Address: _____

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

Primary Phone: _____ **Secondary Phone:**_____

Emergency Contact: _____ **Number:** _____

Guarantor (*Person financially responsible for account*) First Name _____Last_____

DOB:___/___/____**SSN:**____-____-_____ **Sex:** Male ☐ Female ☐

Insurance Information

Subscriber Name:_____ **Sex:** Male ☐ Female☐ **DOB**____/____/____

Insurance Company:_____ ID #_____ Group #_____

Release of Information to Spouse/Relatives/Friends and HIPAA Notice

I give permission for these specified persons to obtain/request/discuss any of my appointments/prescriptions/ medical/billing information during the duration of my time here as a patient at Deer Park Family Care Clinic. I understand that any time during this period I can revoke the privileges to the assigned names below and will inform DPFCC staff of any deletions or additions to the persons allowed to receive this information. Once health care information is disclosed, the person that receives it may re-disclose it, and privacy laws may no longer protect it. This contract will **expire in one year** and will need to be filled out and updated one year from the signed date. Any information I **do not** want disclosed (STD, substance abuse, mental health information, HIV, pregnancy, sterilization or other information) will be written in the comment section below. If you would like a copy of the HIPAA privacy policy please ask at the front desk.

Name: _____Phone:_____ Relation: Spouse/Significant Other

Name: _____Phone:_____ Relation: _____

Name: _____Phone:_____ Relation: _____

Comments: _____

Would you like us to leave detailed messages on your primary phone number answering machine? Yes ☐ No ☐

I certify that all information is true and correct. I authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance carrier and /primary Doctor. In making this assignment, I authorize payment to be made directly to Deer Park Family Care from my insurance Company. I understand and agree that I am financially responsible for co-pays and deductibles at the time of service. Any charges not paid by the insurance company will become my responsibility and is due immediately.

_____ _____ _____

Signature of person financially responsible **Date** **Accepted by**

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)

Adress:_____ City:_____ State:____

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

-OR-

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

Adress:_____ 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