OAK GROVE FAMILY MEDICAL CLINIC
ACCOUNT INFORMATION

❒ Male ❒ Female

Patient Name: ______________________________
Last First Middle

Mailing Address: ______________________________

City, State, Zip: ______________________________

Employer/School: ____________________ **Pt. Email:** ____________________

Preferred Phone: ____________________ **Optional Phone:** ____________________

Patient SS#: ____________________ **Marital Status:** __________ **Date of Birth:** _______

Guardian Info: ____________________ **Date of Birth:** ____________________

SS#: __________ **Employer:** __________ **Work Phone:** __________

Spouse Name: ____________________ **Date of Birth:** ____________________

SS#: __________ **Employer:** __________ **Work Phone:** __________

Emergency Contact: ____________________ **Phone #:** __________
Name Relationship

Preferred Pharmacy: ____________________ **Mail Order:** ____________________

Race: ❒ Asian ❒ Black ❒ Caucasian ❒ Asian Pacific ❒ Native American ❒ Hispanic ❒ Native Alaskan ❒ Native Hawaiian ❒ Other ____________________

Primary Insurance: ____________________ **Employer:** ____________________

Group #: ____________________ **ID#:** ____________________

Policyholder: ____________________ **DOB:** ____________________

Secondary Insurance: ______________________________

Group #: ____________________ **ID#:** ____________________

Policyholder: ____________________ **DOB:** ____________________

Referred By: ______________________________

AUTHORIZATION FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE THE ABOVE DOCTOR/DOCTORS TO PROVIDE SUCH MEDICAL SERVICES INCLUDING SURGERY, IF NECESSARY, EITHER REGULAR OR EMERGENCY, AS MAY BE DETERMINED TO BE IN THE BEST INTEREST OF THOSE MEMBERS OF MY IMMEDIATE FAMILY AS LISTED ABOVE, WHO ARE MINORS. THIS AUTHORIZATION SHALL CONTINUE AND BE IN FULL FORCE AND EFFECT UNTIL REVOKED IN WRITING BY ME.

______________________________ ____________________
PARENT OR GUARDIAN DATE

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE THE ABOVE DOCTOR/DOCTORS TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY ASSIGN TO THE DOCTORS ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSE RELATIVE TO THE SERVICE PERFORMED FROM TIME TO TIME, BUT NOT TO EXCEED BY INDEBTEDNESS TO SAID PHYSICIANS AND SURGEONS. IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE NAMED INSURANCE COMPANY OVER AND ABOVE MY INDEBTEDNESS WILL BE REFUNDED TO ME WHEN MY BILL IS PAID IN FULL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

______________________________ ____________________
PATIENT SIGNATURE OR RESPONSIBLE PARTY DATE

HEALTH AND HISTORY QUESTIONNAIRE

OAK GROVE FAMILY MEDICAL CLINIC

Name: ______________________________ Date: ______________________

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Health of Spouse: ❑ Good ❑ Fair ❑ Poor

List Household Members: ______________________________

____

Your Occupation(s): ______________________________

Your Exercise Routine: ______________________________

Sleep (hours per night): ______________________________

(For the items below, list the type you use & how much per day)

Sleeping Aids: ______________________________

Alcohol: ______________________________

Tobacco: ______________________________

Caffeine: ______________________________

Do you have a living will? ❑ Yes ❑ No

Do you wish to have one? ❑ Yes ❑ No

Have you ever abused alcohol/drugs ❑ Yes ❑ No

Have you ever had:	Yes	No
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Back Trouble	Y	N
Bladder Infection	Y	N
Bleeding Tendency	Y	N
Blood Transfusion	Y	N
Bronchitis	Y	N
Cancer	Y	N
Diabetes	Y	N
Diphtheria	Y	N
Glaucoma	Y	N
Emphysema	Y	N
Hay Fever	Y	N
Heart Disease	Y	N
Hemorroids	Y	N
Heatitis	Y	N
High Blood Pressure	Y	N
Hives	Y	N
Infectious Mono	Y	N
Kidney Disease	Y	N
Malaria	Y	N
Measles	Y	N
Meningitis	Y	N
Mumps	Y	N
Whooping Cough	Y	N
Pleurisy	Y	N
Pneumonia	Y	N
Polio	Y	N
Rheumatic Fever	Y	N
Thyroid Disorder	Y	N
Tuberculosis	Y	N
Exposure to TB	Y	N
Ulcer	Y	N

Other Illnesses: ______________________________

Operations:	Yes	No	Year
Appendix	Y	N	______
Breast	Y	N	______
Gallbladder	Y	N	______
Heart	Y	N	______
Hernia	Y	N	______
Prostate	Y	N	______
Stomach	Y	N	______
Thyroid	Y	N	______
Tonsils	Y	N	______
Uterus/Overy	Y	N	______
Varicose Veins	Y	N	______

Others: ______________________________

Other Hospitalizations: Reasons	Year

Injuries	Year

Immunizations:	Yes	No	Year
Hepatitis A	Y	N	______
Hepatitis B	Y	N	______
HIB	Y	N	______
MMR	Y	N	______
Pneumonia	Y	N	______
Polio	Y	N	______
Tetanus	Y	N	______

Others: ______________________________

MEDICINES TAKEN REGULARY	REASON

MEDICINES/SUBSTANCE ALLERGIES	REACTION

FAMILY HISTORY: Has any blood relative had the following:

	Yes	No	Relation
Alcoholism	Y	N	
Anemia	Y	N	
Arthritis	Y	N	
Asthma	Y	N	
Bleeding Tendency	Y	N	
Cancer	Y	N	
Chronic Lung Disease	Y	N	
Depression	Y	N	
Diabetes	Y	N	
Hay Fever/Allergies	Y	N	
Heart Disease	Y	N	
High Blook Pressure	Y	N	
Kidney Disease	Y	N	
Leukemia	Y	N	
Mental Illness	Y	N	
Migraine Headache	Y	N	
Obesity	Y	N	
Peptic Ulcer	Y	N	
Seisures	Y	N	
Stroke	Y	N	
Thyroid Problems	Y	N	

Relative	IF LIVING, HEALTH		IF DECEASED
	Age	Good Fair Poor	Age(at death) Cause of death
Father			
Mother			
Brother/Sisters (circle sex)			
M F			
M F			
M F			
M F			
M F			
M F			
Children (circle sex)			
M F			
M F			
M F			
M F			
M F			
M F			
M F			
M F			

AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: ____

____

to disclose a copy of the specific health information described below regarding:

Patient Name:____**DOB**__________

consisting of: (Describe information to be used/disclosed)

____

____

to: (Name and address of recipient or recipients)

____

____

for the purpose of: (Describe purpose of disclosure.)

____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_________ **HIV/AIDS information**
_________ **Mental health information**
_________ **Genetic testing information**
_________ **Drug/alcohol diagnosis, treatment, or referral information**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is when the health care services are solely for the purpose of providing health information to someone else and the autorization is necessary to make that disclosure.
You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.
To revoke this authorizaton please send a written statement indicating that your are revoking this authorization to:

____
(Contact Person)

at: ____
(Address of person/entity disclosing information)

SIGNATURE:
(Insert either applicable date or event)
I have read this authorization and I understand it. Unless revoked, this authorization expires__________________

(Print)____ ________________________
(Print Patient's Name) ***(Patient's date of birth)***

Sign: X____ **Date:** ____________________
(Patient or personal representative -- Signature)

OAK GROVE FAMILY
MEDICAL CLINIC

Authorization for Family Members/Friends

Patient Name:____ DOB: ______________________________

Patient to complete the following:

I authorize ____
Names/Relationships

____

____

____

for the following purpose:

____

____

____

This authorization is valid from _________________________ and expires on __________________________.

I understand that I may refuse to sign this authorization.

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to informatiohn already disclosed while the authorization was in effect.

Signed: ____ Date: ________________________

OAK GROVE FAMILY MEDICAL CLINIC

2250 Southeast Oak Grove Blvd., Suite B
Oak Grove, Oregon 97267
Phone: (503) 654-6567
FAX: (503) 653-2582

HIPAA ACKNOWLEDGEMENT AND CONSENT

I (***print patient name)*****_____________________________, understand that Oak Grove Family Medical Clinic** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my **health information** in order to:

- make decisions about and plan for my care and treatment;
- remind me of appointments;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of This Practice's Notice of Privacy Practices that is in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I undestand that The Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above. A copy of the Notice of Privacy Practices is available upon request.

Sign: ______________________________ Date: ____________________
Patient

- OR -

Sign: ______________________________ Date: ____________________
Patient Representative (if minor is under 18)

Description of Prepresentative's Authority:______________________________