OAK GROVE FAMILY MEDICAL CLINIC

Doctor: ______________________

ACCOUNT INFORMATION

☐ Male ☐ Female

Patient Name: ______________________
Last First Middle

Mailing Address: ______________________ Acct #: __________

City, State, Zip: ______________________

Employer/School: ______________________ Pt. Email: __________

Preferred Phone: __________ 2nd Phone: __________ Cell: __________

Patient SS# __________ Marital Status __________ Date of Birth: __________

Responsible Party Name: ______________________ Date of Birth: __________

SS#: __________ Employer: __________ Work Phone: __________

Spouse Name: ______________________ Date of Birth: __________

SS#: __________ Employer: __________ Work Phone: __________

DEPENDENT INFORMATION

First Name	Middle Name	Last Name	Sex M | F	Birthdate	Soc. Sec. No.
First Name	Middle Name	Last Name	Sex M | F	Birthdate	Soc. Sec. No.
First Name	Middle Name	Last Name	Sex M | F	Birthdate	Soc. Sec. No.

Contact in Case of Emergency: ______________________ Phone #: __________

Primary Insurance Co.: ______________________ Employer __________

Policy Numbers: Group #: __________ ID#: __________

Policyholder: ______________________ DOB: __________

2nd Insurance Coverage: ______________________

Policy Numbers: Group #: __________ ID#: __________

Policy Holder: ______________________ 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**

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 MY 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.

______________________ ______________
RESPONSIBLE PARTY OR PATIENT SIGNATURE **DATE**

HEALTH AND HISTORY QUESTIONNAIRF

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 (how many 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/prescription/illegal drugs? ❑ Yes ❑ No

Circle "Y" (yes) or "N" (no)

Have you ever had:	
Anemia	Y N
Arthritis	Y N
Asthma	Y N
Back Trouble	Y N
Bladder Infect.	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
Hemorrhoids	Y N
Hepatitis	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
Scarlet Fever	Y N
Thyroid Disorder	Y N
Tuberculosis	Y N
Exposure to TB	Y N
Ulcer	Y N

Other Illnesses: (list)	Year diagnosed

Operations:		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/Ovary	Y N	
Varicose Veins	Y N	

Others: (list)

Other Hospitalizations:

Reason	**Year**

Injuries:	**Year**

Immunizations:		**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: (list)

MEDICINES TAKEN REGULARLY	**REASON**

MEDICINES/SUBSTANCES ALLERGIC TO	**REACTION**

FAMILY HISTORY – Has any blood relative had any of the following: Circle "Y" (yes) or "N" (no); if yes, what relationship:

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 Blood 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	
Seizures	Y N	
Stroke	Y N	
Thyroid Problems	Y N	

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

OAK GROVE FAMILY MEDICAL CLINIC

2250 Southeast Oak Grove Blvd, Suite B
Oak Grove, Oregon 97267
503/654-6567
Fax 503/653-2582

ACKNOWLEDGMENT AND CONSENT

I ______________________________ 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, diagnoses, 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 health care; 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 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 understand that This 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, and that I have received a copy of the Notice of Privacy Practices.

By: ______________________________ Date: ______________
(Patient)

-OR-

By: ______________________________ Date: ______________
(Patient representative)

Description of Representative's Authority: ______________________________

AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: ____
to use and disclose a copy of the specific health information described below regarding:

*(Name of individual)*____

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

____

____

____

to: *(Name and address of recipient or recipients)*

____

____

for the purpose of: *(Describe each 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 authorization 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 cannon be undone.

To revoke this authorization, please send a written statement indicating that you are revoking this authorization to:

____
(Contact person)

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

SIGNATURE:

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

______________________________ ______________________
(Name of individual -- please print) *(Individual's date of birth)*

By: ______________________________ Date: ______________________
(Individual or personal representative)

Description of personal representative's authority:______________________________

AUTHORIZATION

Patient Name: ______________________ Date of Birth: ___________________

Patient to complete the following:

I authorize ______________________________ to use the following information:

____

____

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 information already disclosed while the authorization was in effect.

Signed: _________________________________ Date: __________________

Please file in patient chart and provide copy to patient at time of signature.