NEW PATIENT INQUIRY SHEET

Today's Date / Fecha de hoy: ______________________________

Patient's Name/Nombre del paciente:______________________________________

Date of Birth/Fecha de Nacimiento:_____________________________________

Phone Number/Numero de Telefono:_____________________________________

Is there anyone in your immediate family who is a patient with our clinic? Yes or No/ Hay alguien en su familia immediate que es paciente con nuestra clinica? Si O No

If so name/ Si es asi, el Nombre por favor: _________________________________

Any medical problems acute or chronic/ Cualquier problema de salud ?

____

____

Current medications you are taking / Los medicamentos que esta tomando actualmente:

____

____

IT IS IMPORTANT THAT YOU BE AWARE THAT OUR PROVIDERS DO NOT PROVIDE PAIN MANAGEMENT TO PATIENTS/ ES IMPORTANTE QUE USTED ESTE INFORMADO QUE NUESTROS PROVEEDORES NO MANEJAN DOLOR CRONICO.

Have you been seen in any clinic, hospital, or Medi-Center? If so, which one? Ha sido visto en cualquier clinica, hospital, centros medicos? Si este es el caso cual?

____

Reason for transfer/ Motivo de la transferencia:

____

Type of Insurance / Tipo de aseguransa: ____

How did you hear about our clinic? Como se entero de nuestra clinica?________________________

____

Circle preferred Provider? / Circule su Proveedor Preferido?

Dr. Halma   Dr. Bond   Margaret Kranz, PA-C   Maricela Ramirez, PA-C

Ramon Perez, PA-C   Ismael Vargas,PA-C

I certify that this information is correct and true, if found to be incorrect or false this may affect your acceptance to our clinic. / Certifico que esta informacion es correcta y verdadera, si encontramos que es incorrecta o falsa esto puede afectar aceptacion a nuestra clinica.

X____   Date_____________________________

SWOFFORD & HALMA CLINIC, INC. P.S.

FAMILY PRACTICE

Harlan D. Halma, M.D. · Blake Bond, MD · Marisela Ramirez , PA-C · Margaret Kranz, PA-C

Ramon Perez Jr, PA-C * Ismael Vargas, PA-C *

*****AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION*****

Patient Name______________________________
Date of Birth______________________________
Social Security #___________________________

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION RELEASED TO:
Swofford & Halma Clinic, Inc.
2303 Reith Way
PO Box 119
Sunnyside, WA 98944

INFORMATION TO BE SENT FROM:

____

____

____

Purpose: ________Possible Transfer of Care ___________ OB Care ______Other/Self

________ Newborn-present _____ 2016- Present

The following records are requested for release: _______ All Medical Records _______Progress Notes _______ Lab & X-rays

_______Prenatal History _______Pap Smear _______Ultrasound _______Immunization Record

___/___/___ ______________________________ ________________
Date SIGNATURE OF PATIENT OR OR PATIENT'S AUTHORIZED REP. RELATIONSHIP

___/___/___ ______________________________ ________________
Date SIGNATURE OF WITNESS TITLE

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis, and treatment for:

______HIV/AIDS _______Sexually transmitted diseases ______Psychiatric treatment ______Alcohol/drug use

_______Mental illness

I understand that I do not have to sign this authorization in order to get health benefit (treatment, payment, enrollment or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that: A) I must revoke my authorization in writing and do so by completing and signing the Revocation of Authorization Form available at Swofford & Halma Clinic (SHC); B) If I revoke my authorization, it will not affect any actions already taken by SHC based upon this authorization, and C) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once SHC has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than 90 days after the date of this authorization. This prohibition does not extend to insurance companies.

This authorization will expire 90 days from the date of signature. ***** This is not a transfer of care; patient's application is in the process of being reviewed. *******

___/___/___ ______________________________ ________________
Date SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REP. RELATIONSHIP

Swofford and Halma Clinic, Inc. P.S.
Health Questionnaire

Please provide information which will help construct a complete health record plan.

Name: ______________________ Age: __________ Date: ____________

What medications are you taking regularly?
Name: Dose: Name: Dose:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Are you allergic to any medication or foods? Please list:

____

____

Preferred Pharmacy: ______________________________
List any surgeries: (Example: appendix, gallbladder, hysterectomy, ect.)
Name: Date: Hospital:

____

____

List any major illnesses (diabetes, high blood pressure, heart trouble, chronic lung problem, cancer):
Name: Date Diagnosed: Name: Date Diagnosed:

______________________ ______________________

______________________ ______________________

______________________ ______________________

List serious injuries:
What happened: Date: Hospital:

____

____

Vaccinations

Have you completed all of the usual childhood immunizations (diphtheria, tetanus, whooping cough, oral polio, measles, mumps, and rubella)? ____________________

When was your last tetanus booster? __________________

Do you usually receive a yearly influenza ("flu") shot? _____________

If you work in a health care facility or institution, have you received hepatitis B vaccination? ______________________________

Family Medical History:

	How Many:	Age(s):	Deceased:	Illness:
Mother:		_______	_______	____________________
Father:		_______	_______	____________________
Brother(s):	_______	_______	_______	____________________
Sister(s):	_______	_______	_______	____________________
Children(s)	_______	_______	_______	____________________

List any family members with cancer:

Relationship:	Type of cancer:	Relationship:	Type of cancer:

Personal History:

Present marital status? _____________ Religious preference? __________________

Occupation: ____________________ Spouses occupation? ___________________

Hobbies or Interest: ____

Healthy Habits:

Recreacional Drug (i.e.; marijuana, cocaine, etc) _____________________________

Do you smoke? __________ Packs per day__________ Duration (how long) ______yrs

Do you drink? __________ (Wine___ Beer___ Mixed Drinks___)

How much alcohol do you consume on a regular basis? ______________________

Do you drink caffeine (soda, coffee, energy drinks)?_________ How many?_________

Do you exercise (walk, jogging, biking, etc.)? ______________________________

Do you take or obtain alternative medicine (chiropractor, massage, herbal, ect.)? _______

____

Do you have financial or stressful family problems which may be affecting your health?

____

Obstetrical History (women only)
Dates of Pregnancies and Deliveries: ________________________________

____

Have you had any miscarriages or abortions? ____________________________

What birth control method are you using? ______________________________