# Mid-Willamette Family Medicine

Dr. Flora Yao Dr. Dennis Johnson
1050 29th Ave SW, Albany, OR 97321 (541) 926-4828
PO Box 343, 38829 N Main St, Scio, OR 97374 (541) 926-4828
Fax (541) 926-4891

## ADULT INTAKE FORM

Thank you for your interest in **Mid-Willamette Family Medicine**. We appreciate you considering us for your medical care. Please complete the intake packet and return it to our office. The information will only be used to help determine if we are a good fit for your healthcare needs and will remain strictly confidential.

Please be aware, submitting this form and/or leaving your information with a receptionist is the first step of the intake process and does not establish a doctor-patient relationship. We strongly encourage you to continue with your current provider, especially if you have an urgent medical need.

**We will reach out to you after our doctors have reviewed the completed intake form.**

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**Patient's Last Name:** _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____/_____/_____ Social Security# _____- _____- _____ Sex: Male/Female Driver's License#: _____

Marital Status: Single Married Divorced Widowed

Address: _____ PO Box: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave you a voicemail/text message containing personal and/or confidential information? Yes / No

Current Employer/School: _____ Occupation/Grade: _____

Is anyone in your family a current patient? Yes / No If yes, Name: _____

Were you referred? Yes / No If so, who referred you to us? _____ Phone: _____

Have you been treated by a primary care provider within the past year? Yes / No

If yes, what is the provider's name: _____

Are you involved in: Worker's compensation claim Motor vehicle accident 3rd Party Liability Other: _____

If so, please explain: _____ Accident Date: _____

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**Responsible Party Last Name:** _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____/_____/_____ Social Security# _____- _____- _____ Sex: Male/Female Driver's License#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Current Employer/School: _____ Occupation/Grade: _____

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**Emergency Contact's Name:** _____ Relationship: _____ Phone: _____
May we leave you a voicemail message containing personal and/or confidential information with your Emergency Contact? Yes / No

Do you have an Advanced Directive? Yes / No

**Primary Insurance Plan:** _____ ID#: _____ Group#: _____

Subscriber: Self Spouse Parent Other Name: _____ Date of birth: _____/_____/_____

**Secondary Insurance Plan:** _____ ID#: _____ Group#: _____

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Subscriber: Self Spouse Parent Other Name: _____ Date of birth: _____/_____/_____

| **Medical Problems:** | **Year** | **Previous Surgeries:** | **Year** |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**Family Medical History: (i.e. Asthma, Cancer, Diabetes, Heart Attack, Stroke, etc.)**

Mother: _____ Father: _____

Sibling(s): _____ Other: _____

***Please be aware that Dr. Yao/Dr. Johnson do not treat chronic pain or prescribe narcotics or benzodiazepines.**

**Initials:** _____

**Medications:**

| Name | Strength/Dose | Directions on bottle/package |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergies to medications:**

| Name | Reaction |
|---|---|
| | |
| | |

**Date of Most Recent:**

| | | | |
|---|---|---|---|
| Mammogram | Colonoscopy | Shingles Vaccination | Tetanus Vaccination |
| Pap Smear | Dexa (Bone) Scan | Pneumonia Shot | Flu Shot |

Tobacco Use: (circle all that apply) Cigarettes Pipe Chew Cigar Vape Pen Other

Amount Per Day: _____ Year Started: _____ Year Quit: _____

Alcohol Use: Type: _____ Amount: _____ Frequency: _____

Caffeine: Type: _____ Amount: _____ Frequency: _____

**SIGNATURE:** _____ **DATE:** _____

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## CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

PATIENT NAME: _____

Address: _____

Telephone: _____ Email: _____ SSN: _____

## PLEASE CAREFULLY READ THE FOLLOWING STATEMENTS

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare options.

NOTICE OF PRIVCY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, or the uses and disclosures we may make of your PHI, and of other important matters about your PHI. A copy of our Notice is found on the website and at our front desk. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer, Dr. Flora Yao. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONSENT

I, _____, have had full opportunity to read and consider the context of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and health care operations.

**SIGNATURE: _____ DATE: _____**

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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## OFFICE POLICIES

### Appointments

1. We value the time we have set aide to see and treat you. We do not double book appointments. If you are not able to keep an appointment, we would appreciate a 24-hour cancellation notice.
2. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

### No Shows

We define "no show" as a patient who:

1. Fails to arrive or arrives 10 or more minutes after the expected arrival time for the scheduled appointment.
2. Fails to provide notification of their inability to keep the appointment at least 3 hours prior to the scheduled appointment. Ideally, we ask you for cancellation notice 24 hours in advance. Cancellations can be left on our voicemail after hours.

We do understand emergencies may arise preventing you from keeping your appointment. We allow 2 "no show" visits after which we reserve the right to dismiss you from our practice.

### Financial Responsibility

1. You are responsible for any and all co-payments, deductibles, and coinsurances, according to your insurance plan.
2. Co-payments are due at the time of service.
3. Self-pay patients are expected to pay for services in FULL at the time of the visit.
4. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice to submit to your insurance for reimbursement.
5. Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
6. If you have a high-deductible health insurance plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
7. We accept cash, checks, credit, debit, and health savings account debit or credit cards.
8. You will be charged $50 for any checks returned for insufficient funds.

By providing health insurance information to our office and signing this form, you affirm the information provided is correct and authorize us to bill said insurance on your behalf.

### Prescription Refill

1. For monthly medication refills, please contact your pharmacy. The pharmacy will then route the request to our office. Please allow 48-72 hours for your request to be filled. If we require additional information or an office visit, we will contact you.
2. Patients who signed up for the Patient Portal will have another method to use in requesting medications.

**Signature:** _____ **Date:** _____

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## VOLUNTARY INFORMATION DISCLOSURE

Mid-Willamette Family Medicine strives to provide the highest quality of medical services for all our patients. As our patient, we need your help.

As a part of health care reform, medical providers using Electronic Health Records are being asked to collect information about their patients related to ethnicity and race. The information is used to benchmark trends in public health data. Your answers to the following questions are voluntary and confidential as protected by HIPPA laws. You can learn more from Population Reference Bureau at www.prb.org/questionnaire/

Please take a few minutes to answer the following questions:

Print Name: _____ Date of Birth: _____

Race:
- ☐ Caucasian
- ☐ Native American or Native Alaskan
- ☐ Asian or Asian American
- ☐ African or African American
- ☐ Other: _____
- ☐ Prefer not to answer

Language:
- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Other: _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to answer

Status:
- ☐ Smoker
- ☐ Non-smoker

At this time, our Clinic is requesting an email address from our patients for future communications related to our Electronic Health Records. Your email will only be used for the purpose of patient communications and will not be shared with any third party. If you are willing to provide your email address, please write it below. You will be given the opportunity to receive a real-time connection to your health information online, with access to your diagnosis history, medication details, immunizations, lab results, and appointments.

Email Address: _____