606 N. 3rd Ave Suite 101
Sandpoint, ID 83864
Ph#208.263.1435
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www.fhcsandpoint.com

Scott Dunn, MD
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Jeremy Waters, MD
Kara Waters, DO
Zach Halversen, MD
Jane Hoover, FNP

**Welcome to Family Health Center! Where healthcare is a team approach with you, the patient, at the center of your own care.**

Here are a few things you need to know:

- If your insurance requires you to designate a PCP please contact them ***prior to your appointment*** to let them know you have changed physicians or they may not pay for your visit. That means you may get a bill for the full cost of the visit.
- Please bring your insurance card and picture ID with you to your appointment.
- Regarding your previous medical records - We only need your most recent office visit and medication list, recent labs, recent radiology reports and any immunization records be sent to our office.
- If we do not have your new patient paperwork 24 hours prior to your appointment we may have to cancel your appointment. Please return your paperwork as soon as possible.
- If you are taking pain medications please talk with our front office staff.

**Thank you for choosing Family Health Center for your medical needs!**

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## *Your New Medical Home*

Family Health Center is a Patient-Centered Medical Practice dedicated to the health and wellness of the patients and community we serve. Our certification as a Patient-Centered Medical Home (PCMH) means our physicians and staff are committed to comprehensive, personal healthcare centered around you; partnering with you to ensure all of you and your family's medical and non-medical needs are met.

### *Your Personal Physican*

The relationship between you, your physician, and the care team is the driving force behind a Patient-Centered Medical Home. Your physician will provide medical care that is right for you based on evidence-based guidelines shown to improve health.

### *Your Care Team*

Your physician will direct the care team to coordinate your care based on YOUR wants and needs.

To improve efficiency, the care team will plan for your appointment by:

- ✓ reviewing your medical chart for up-to-date forms.
- ✓ check for recent testing.
- ✓ ensure you are notified of results in a timely manner.
- ✓ coordinate your healthcare across all care settings including the medical office, hospital, behavioural health, testing facilities and other places where you may receive care.

If you are admitted to the hospital, you will receive a phone call from your care team upon your discharge to review your hospital stay, make sure you return for follow-up care, and discuss any questions or concerns you may have about your treatment or medications.

### *Your Health*

In return, we ask that you be an active participant in your health care. We ask that you take charge of your health by managing and monitoring aspects of your care.

You should:

- ✓ Let us know if there are any changes in your medications and bring a list of your medications with you to your visits.
- ✓ Let us know if you are getting care from other healthcare providers, any hospitalizations, or ER visits.
- ✓ Tell us about any complementary and natural treatments you are getting.
- ✓ Provide a complete medical history so you get the best care possible.
- ✓ Identify previous doctors so our medical records staff can request important notes and test results.

### *Quality for you*

As a PCMH we are committed to providing same day appointments and offering expanded hours to meet your needs. We will use our electronic health record to support the best care, quality, and safety by helping us to identify and provide for your needs and the needs of our entire patient population. We are able to communicate with you electronically through our secure Patient Portal, along with sending you reminders for appointments and preventative or chronic care services due.

*If you ever have any questions please just ask. Your care team is here to help!*

*Thank you for choosing Family Health Center as your Medical Home!*

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# Pediatric New Patient Paperwork

Child's Last Name: ________________________ First Name: _____________________ Middle Initial: _____ Nickname: ___________

Birthdate: ______________________ Age: _________ Gender: _________ SS#: _______________________________________

Child's Mailing Address: ________________________________________ City: ____________________ St: ______ Zip: ___________

Patient Insurance: ______________________________________________ Policy #: _________________________________________

Mother's Name: ____________________________________________ Birthdate: ________________ Phone:_________ __________

Mother's Address: ___________________________________________ City: ______________________ St: ______ Zip: ___________

Social Security #: _________________________________ Email Address: ________________________________________________

Employer's Name: _________________________________________ Work Phone: _____________________________________

Father's Name: ____________________________________________ Birthdate: ________________ Phone:_________ __________

Father's Address: ___________________________________________ City: ______________________ St: ______ Zip: ___________

Social Security #: _________________________________ Email Address: ________________________________________________

Employer's Name: _________________________________________ Work Phone: _____________________________________

Does this child primarily live with: ☐ Father ☐ Mother ☐ Other Adult _______________________________________________

Does this child at times live with adults other than above? ☐ Yes ☐ No

Name ______________________________________________________ Relationship _______________________________________

Address __________________________________________________________________ Phone______________________________

What doctor / clinic have/has taken care of this child in the past? ___________________________________________________

| **Preferred Contact** | **Preferred Contact** | **Ethnicity** | **Race** |
|---|---|---|---|
| ☐ Mail<br>☐ Home Phone<br>☐ Cell Phone<br>☐ Patient Portal<br>☐ E-Mail<br>Email address:<br>________________________________ | ☐ Mail<br>☐ Home Phone<br>☐ Cell Phone<br>☐ Patient Portal<br>☐ E-Mail | ☐ Hispanic/Latino<br>☐ Non-Hispanic | ☐ American Indian or Alaskan Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian/Other Pacific Islander<br>☐ White<br>☐ Other |

I/We do herby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Family Health Center to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained heron are true. I understand that I am directly responsible for all charges incurred for medical services for dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also herby authorize Family Health Center to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

____________________________________ ________________________
Signature of Parent/Legal Guardian Date

____________________________________ ________________________
Printed Name of Parent/Legal Guardian Date

# Acknowledgement of Notice of Health Information Practices

We have made available to you our Notice of Health Information Practices. PLEASE REVIEW THIS NOTICE CAREFULLY! You may have a personal copy of the Notice, or you may access the Notice online at www.fhcsandpoint.com.

***The Notice explains when we might use/disclose your health information, and includes some of the following examples:***

- when you give us permission to disclose your health information
- to aid in your treatment or to persons involved in your health care or the payment for such
- to help us or other health care providers get paid for services provided to you
- to improve our health care operations
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

***The Notice also explains some of your rights under HIPAA, including but not limited to your:***

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your health information in our records
- right to request that we correct health information in your record that is wrong or misleading
- right to be notified when a breach of your health information has occurred
- right to have us tell you to whom we have disclosed your health information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

**I acknowledge that I have been given an opportunity to review this facility's Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.**

________________________________ __________ ________________________________

*Signature* *Date* *Printed name*

*Relationship to patient (if not the patient)/description of authority to act for patient:* ____________________

*FOR FHC USE ONLY:*

*Date Notice Made Available:* ___________ *Notice Delivered: in person* __ *mail* __ *electronic* __

Acknowledgement Signed? Y or N

*Why Acknowledgement Not Signed: patient refused*__ *patient failed to return* __ *emergency* __ *other* __

Reason for today's visit: ____________________________________________________________

Preferred Pharmacy: ____________________________________________________________

## Pregnancy and Birth

**(If child is currently under 12 months old)**

Where was baby born? ____________________________________________________________

Birth Weight ________ Birth Length ________ Age of Mother at Baby's birth ______

Infant's gestational age: ☐ Full term ______ ☐ Preterm _____ If so, how many weeks ______ ☐ Post term ______

Type of Delivery: ☐ Vaginal _____ ☐ C-section _____ If so, reason ________________________________________

Were there any medical problems during the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor), Labor or Nursery? ____________________________________________________________

Did baby experience any jaundice? ☐ Y ☐ N

Did baby have their newborn hearing test? ☐ Y ☐ N

Did baby have their PKU test (also known as Newborn Health Screening / Heel Poke) ☐ Y ☐ N

| **Medications – List all medications your child takes, prescription and non-prescription, and the dosage** | | |
|---|---|---|
| ☐ ***No Medications*** | | |
| **Medication Name** | **Dosage** | **Frequency** |
| | | |
| | | |
| | | |

| **Medication & Food Allergies – List all known allergies (drugs, food, animals, etc.)** | |
|---|---|
| ☐ ***No Allergies*** | |
| **Allergy** | **Reaction** |
| | |
| | |
| | |
| | |

## Growth and Development

Are there any problems with the child's behavior in the home? ☐ Yes ☐ No If yes, please explain:

____________________________________________________________

____________________________________________________________

If child is old enough for school, are there any school problems (learning, social, behavioral, coordination)?
☐ Yes ☐ No If Yes, please explain:

____________________________________________________________

____________________________________________________________

| Has your child had any of the following? | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Yes | No | Date | | Yes | No | Date |
| Anemia | | | | Heart trouble / murmur | | | |
| Appendicitis | | | | Inability to get to sleep? | | | |
| Asthma | | | | Kidney disease | | | |
| Bladder infection | | | | Loss of urinary bladder control? | | | |
| Bleeding with bowel movements | | | | More than six colds in a year? | | | |
| Bloody, red or brown urine | | | | More than two earaches in a year? | | | |
| Broken Bones | | | | Pneumonia | | | |
| Chickenpox | | | | Rheumatic fever | | | |
| Chronic cough/frequent bronchitis | | | | Shortness of breath with exercise? | | | |
| Concussion(s) | | | | Stuffy nose most of the time? | | | |
| Convulsions/seizures | | | | Treated for accidental poisoning | | | |
| Eczema/sensitive skin | | | | Tonsil-Adenoid surgery | | | |
| Fainting spells | | | | Trouble hearing | | | |
| Frequent bad stomachaches | | | | Unconscious from an injury | | | |
| Frequent nightmares | | | | Weak eye muscles (cross eyes or wall eyes)? | | | |
| Frequent urination? | | | | Whooping cough | | | |
| Frequent vomiting? | | | | Other serious injuries: ______________________________ | | | |
| Headaches more than twice a month? | | | | Hospitalized for reasons other than those listed: __________________________________ __________________________ | | | |

| Health and Safety | | | | | |
|---|---|---|---|---|---|
| | Yes | No | | Yes | No |
| Does your child get regular dental cleanings? | | | Is the hot water temperature set to less than 125 degrees? | | |
| Does your child use a car seat or seat belt all the time? | | | Do you have rules/limits for screen time? | | |
| Are there smoke detectors in your home? | | | Are medicines or potential poisons out of reach? | | |
| If there are guns in your home are they locked up? | | | Is there an adult in your household who knows child CPR? | | |

| Family History – Check if any family member(s) has had any of the following conditions | |
|---|---|
| Are child adopted? ☐ Yes ☐ No | |
| Relationship | Significant Health Problems (Circle all that apply) |
| Grandmother (Maternal) Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Grandfather (Maternal) Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Grandmother (Paternal) Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Grandfather (Paternal) Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Father Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Mother Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Sister(s) Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |
| Brother(s) Alive? Yes No<br>If No, what was cause of death?<br>____________________<br>____________________ | Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes<br>Heart Attack Heart disease High Cholesterol Renal Disease Stroke<br>Thyroid Disorder Cancer, Type:<br>____________________ |

**Is there anything else we should know about your child's medical history?**

____________________________________________

____________________________________________

____________________________________________