606 N. 3rd Ave Suite 101  Scott Dunn, MD

Sandpoint, ID 83864 Dan Meulenberg, MD

Ph#208.263.1435 Jeremy Waters, MD

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www.fhcsandpoint.com Zach Halversen, MD

Hannah Raynor, 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!*

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*Please complete the following paperwork and return to us 24 hours prior to your appointment.*

**Adult New Patient Paperwork**

**Click in each box to enter text**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Last Name** : | **First Name** : | | **MI**: | | | **DOB**: |
| **Previous Last Name (Maiden)**: | | **Nickname**: | | | | |
| **SSN**:\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ | **Age**: | | | **Gender:**  M or  F | | |
| **Mailing Address**: | **City**: | | | **St**:. | **Zip**:. | |
| **Home Phone**: | | **Cell Phone** : | | | | |
| **Occupation** : | **Employer**: | | | **Ph#**: | | |
| **Insurance** : | | | | **Policy #** : | | |
| **E-Mail Address** : | | | | | | |
| **Preferred Language** : | **Disabled:**  Y or  N | | | **Veteran:**  Y or  N | | |

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| --- | --- | --- | --- | --- |
| **Marital Status**  Married  Single  Divorced  Separated  Widowed  Life Partner | **Preferred Contact**  Mail  Home Phone  Cell Phone  Patient Portal  E-Mail | **How would you like your appointment reminders?**  Text  Email  Phone Call | **Ethnicity**  Hispanic/Latino  Non-Hispanic | **Race**  American Indian or Alaskan Native  Asian  Black or African American  Native Hawaiian/Other Pacific Islander  White  Other |

***Spouse / Significant Other / Emergency Contact***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last Name**: | **First Name**: | | **MI**: | **DOB**: |
| **SSN**: | **Age**: | | **Gender:**  M or  F | |
| **Mailing Address**: | **City**: | | **St**: | **Zip**: |
| **Home Phone**: | | **Cell Phone**: | | |
| **E-Mail Address**: | | | | |
| **Occupation**: | **Employer**: | | **Ph#**: | |
| **Relationship to patient**: | | | | |

|  |
| --- |
| **How did you hear about us**? |
| **Please list any prior providers from whom we will need to obtain prior medical records**: |

**Consent for treatment:**

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians of Family Health Center to me. I certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services 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 authorize Family Health Center to release information requested by insurance companies and/or its’ representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

***Click here to enter text.*** **Click here to enter text.**

**Signature of Patient/Guardian** **Date**

**Click here to enter text.** **Click here to enter text.**

**Printed Name of Patient/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.](http://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 | | | | | |
| • to help us or other health care providers get paid for services provided to you | | | | |  |
| • 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.**  **Please Sign Below:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Click here to enter text.*** **Click here to enter text.**  **Signature of Patient/Guardian** **Date**  **Click here to enter text.** **Click here to enter text.**  **Printed Name of Patient/Guardian** **Date** | | | | | |
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| --- | --- | --- |
| **Patient Name:** | | **DOB:** |
| Main reason for your upcoming visit: | | |
| Which pharmacy will you be using? | | |
| Do you have a living will?  Yes  No | Do you have a designated Medical Power of Attorney?  Yes  No | |
| For female patients – Are you pregnant or trying to become pregnant?  Yes  No | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medications – List all medications you take, 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** | | | |
| . | | | | | . | | | |
| . | | | | | . | | | |
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| . | | | | | . | | | |
| . | | | | | . | | | |
| . | | | | | . | | | |
| **Health Maintenance – Check if you have received the following, and the date of most recent exam** | | | | | | | | |
| **Exam** | **Date** | | **Normal or Abnormal?** | **Exam** | | | **Date** | **Normal or Abnormal?** |
| Colonoscopy | . | | . | Foot Exam (if Diabetic) | | | . | . |
| DEXA Scan | . | | . | Lipid Panel | | | . | . |
| Echocardiogram | . | | . | Mammogram | | | . | . |
| EKG | . | | . | PAP Test | | | . |  |
| Eye Exam (if Diabetic) | . | | . | Wellness Exam | | | . |  |
|  | | | | | | | | |
| **Vaccine** | **Date Received** | | | **Vaccine** | | | **Date Received** | |
| Influenza (Flu) | . | | | Shingles | | | . | |
| Pneumonia  13,  23 | . | | | Tetanus | | |  | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical History – Check if you have ever had or do have any of the following, and year of onset** | | | | | | | | |
| ***None*** | | | | | | | | |
| **Condition** | | **Year Diagnosed** | | **Condition** | | | **Year Diagnosed** | |
| Allergies – What kind?  . | | . | | Diabetes – Type  1 or  2 | | | . | |
| Anxiety | | . | | Heart Attack | | | . | |
| Arthritis | | . | | High Cholesterol | | | . | |
| Asthma | | . | | High Blood Pressure | | | . | |
| Blood Clots – Where?  . | | . | | Osteoporosis | | | . | |
| Cancer – What type?  . | |  | | Renal Disease – Stage?  . | | | . | |
| Coronary Artery Disease | | . | | Stroke | | | . | |
| COPD | | . | | Thyroid Disorder | | | . | |
| Crohn’s Disease | | . | | Other: | | | . | |
| Depression | | . | | Other: | | | . | |
| **Surgical History – Check if you have received the following procedures, year performed and outcome** | | | | | | | | |
| ***None*** | | | | | | | | |
| **Surgical Procedure** | **Year Completed** | **Outcome of Surgery** | | **Surgical Procedure** | **Year Completed** | | **Outcome of Surgery** | |
| Appendectomy | . |  | | *Female Only* | | | | |
| Back Surgery | . | . | | Breast Biopsy |  | |  | |
| Heart Surgery – Type?  . | . | . | | Cesarean Section: |  | |  | |
| Hernia Repair – Type?  . | . |  | | Mastectomy - Cancerous? . |  | |  | |
| Knee Surgery – Type?  . |  | . | | Hysterectomy – Cancerous? . |  | |  | |
| Tonsillectomy | . | . | | If Hysterectomy – what kind? | | | | |
| *Male Only* | | | | Total, removal of both tubes and ovaries | | Total, unilateral of tube and ovary | |
| Vasectomy: |  |  | | Radical | Total | | Vaginal | |
| **Social History** | | | | | | | | |
| Do you have any children?  Yes  No If Yes, How many: \_\_\_\_\_\_\_\_\_Male(s) \_\_\_\_\_\_\_\_\_ Female(s) | | | | | | | | |
| Who do you live with?  Spouse  Child  Caregiver  Other | | | | | | | | |
| Do you use or have you previously used tobacco?  Yes  No If Yes, age started: \_\_\_\_\_\_\_\_\_\_ If former, age quit: \_\_\_\_\_\_\_\_\_\_  If Yes, what kind and how often? \_\_\_\_\_\_\_\_\_\_  Cigarettes - \_\_\_\_\_\_ packs/day  Chew- \_\_\_\_\_\_ cans/day  Cigars-\_\_\_\_\_\_ /day  E-cigs- \_\_\_\_\_\_ /day  Pipe | | | | | | | | |
| Have you been / are you currently exposed to second hand smoke?  Yes  No  What kind? \_\_\_\_\_\_\_\_\_\_ For how long have you been/were you exposed? \_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_\_ /day/week/month  When was your last drink? \_\_\_\_\_\_\_\_\_\_What kind? \_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Do you drink caffeine?  Yes  No How much? \_\_\_\_\_\_\_\_\_\_ If yes, what type?  Coffee  Tea  Energy drinks  Soda | | | | | | | | |
| Do you exercise?  Yes  No How often? \_\_\_\_\_\_\_\_\_\_ If yes, what type of exercise do you do? \_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Family History – Check if any family member(s) has had any of the following conditions** | | | | | | | | |
| ***Are you adopted?  Yes  No*** | | | | | | | | |
| **Relationship** | | | **Significant Health Problems (mark all that apply)** | | | | | |
| Grandmother (Maternal) Alive?  Yes  No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Grandfather (Maternal) Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Grandmother (Paternal) Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Grandfather (Paternal) Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Father Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Mother Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Sister(s) Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Brother(s) Alive? Yes No  If No, what was cause of death?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Alzheimer’s Arthritis Asthma Blood disorder Depression Diabetes  Heart Attack Heart disease High Cholesterol Renal Disease  Stroke Thyroid Disorder Cancer, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | | | |

*Thank you for choosing Family Health Center to provide you with your medical care. We look forward to getting to know you and your family!*

*Rev: 4/26/18*