

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



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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!



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 Physician

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

Adult New Patient Paperwork

Last Name:		First Name:		MI:	DOB:
Previous Last Name (Maiden):			Nickname:		
SSN:	Age:		Gender: <input type="checkbox"/> M or <input type="checkbox"/> F		
Mailing Address:			City:	St:	Zip:
Home Phone:			Cell Phone:		
Occupation:	Employer:		Ph#:		
Insurance:			Policy #:		
E-Mail Address:					
Preferred Language:		Disabled: <input type="checkbox"/> Y or <input type="checkbox"/> N		Veteran: <input type="checkbox"/> Y or <input type="checkbox"/> N	

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

Last Name:		First Name:		MI:	DOB:
SSN:	Age:		Gender: <input type="checkbox"/> M or <input type="checkbox"/> 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.

 Signature of Patient/Guardian

 Date

 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.

Signature of Patient/Guardian

Date

Printed Name of Patient/Guardian

Date

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

Medications – List all medications you take, prescription and non-prescription, and the dosage		
Medication Name	Dosage	Frequency

Medication & Food Allergies – List all known allergies (drugs, food, animals, etc.)	
Allergy	Reaction

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 (Female only)		
Eye Exam (if Diabetic)			Physical/Wellness Exam		

Vaccine	Date Received	Vaccine	Date Received
Influenza (Flu)		Shingles	
Pneumonia <input type="checkbox"/> 13, <input type="checkbox"/> 23		Tetanus	

Medical History – Check if you have ever had or do have any of the following, and year of onset

Condition	Year Diagnosed	Condition	Year Diagnosed
<input type="checkbox"/> Allergies - What Kind? _____		<input type="checkbox"/> Diabetes - Type 1 or 2	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Asthma		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Blood Clots – Where? _____		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cancer – What Type? _____		<input type="checkbox"/> Renal Disease – Stage? _____	
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Stroke	
<input type="checkbox"/> COPD		<input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Crohn’s Disease		<input type="checkbox"/> Other:	
<input type="checkbox"/> Depression		<input type="checkbox"/> Other:	

Surgical History – Check if you have received the following procedures, and year performed

<input type="checkbox"/> None					
Surgical Procedure	Year Completed	Outcome of Surgery	Surgical Procedure	Year Completed	Outcome of Surgery
<input type="checkbox"/> Appendectomy			Female Only		
<input type="checkbox"/> Back Surgery			<input type="checkbox"/> Breast Biopsy		
<input type="checkbox"/> Heart Surgery			<input type="checkbox"/> Cesarean Section		
Type:			<input type="checkbox"/> Mastectomy		
<input type="checkbox"/> Hernia Repair			<i>Cancerous:</i>		
Type:			<input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Knee Surgery			<i>Cancerous:</i>		
Type:			<i>If Hysterectomy – what kind?</i>		
<input type="checkbox"/> Tonsillectomy			<input type="checkbox"/> Total, removal of both tubes and ovaries	<input type="checkbox"/> Total, unilateral of tube and ovary	
Male Only			<input type="checkbox"/> Radical	<input type="checkbox"/> Total	<input type="checkbox"/> Vaginal
<input type="checkbox"/> Vasectomy					
<input type="checkbox"/> Other:					

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 tobacco? Yes No If Yes, age started: _____ If former, age quit: _____

If Yes, or if former user, 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 (Circle 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: _____

Is there anything else we should know about your medical history?

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!

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Authorization for Release of Medical Information

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

Release Records from: _____

City: _____ State: ___ Phone #: _____ Fax #: _____

Requesting Records be sent to: Family Health Center

Circle PCP: Dr. Dunn; Dr. Halversen; Jane Hoover, FNP; Dr. Meulenberg; Dr. Raynor;
Dr. J. Waters; Dr. K. Waters

Information to be released:

- | | |
|---|--|
| <input type="checkbox"/> Bone Density | <input type="checkbox"/> Last 4 lab results |
| <input type="checkbox"/> Colonoscopy report & pathology | <input type="checkbox"/> Mammogram & pathology |
| <input type="checkbox"/> Current medication list | <input type="checkbox"/> MRI Results |
| <input type="checkbox"/> CT Results | <input type="checkbox"/> Optical Report |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Pap Results |
| <input type="checkbox"/> Last 4 Chart notes | |

Other: _____

Purpose for which disclosure is being made: (Please check one of the following)

- Attorney Doctor Insurance Personal Other _____

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

- ____ Drug/Alcohol abuse/treatment & diagnosis ____ Sexually Transmitted Disease
 ____ Mental Illness or Psychiatric diagnosis/treatment ____ HIV/AIDS diagnosis/treatment/testing

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed by this authorization. **There may be a charge for these copies.**

I understand that this authorization is valid for 1 year from the date signed or on ____/____/____ (MM/DD/YY).

I understand that I may revoke this authorization at any time by notifying Family Health Center in writing, but if I do it will not have any affect on any actions Family Health Center took before they received the revocation.

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.

Signature of Patient or Patient Representative

Date

*Please provide documents to prove authority to sign on behalf of the patient.