606 N. 3rd Ave Suite 101
Sandpoint, ID 83864
Ph#208.263.1435
Fax# 208.263.4580
www.fhcsandpoint.com
email: newpatient@fhcsandpoint.com

Family Health Center
your medical home

Scott Dunn, MD
Zach Halversen, MD
Dan Meulenberg, MD
Hannah Raynor, MD
Jeremy Waters, MD
Kara Waters, DO
Emilie Kuster, 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 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, behaviroal 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: ☐ M ☐ 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	
Hearing impairment: ☐ Y or ☐ N	Vision Impairment: ☐ Y or ☐ N	Memory Impairment: ☐ Y or ☐ N	

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
☐ Married	☐ Mail	☐ Hispanic/Latino	☐ American Indian or Alaskan Native
☐ Single	☐ Home Phone	☐ Non-Hispanic	☐ Asian
☐ Divorced	☐ Cell Phone		☐ Black or African American
☐ Separated	☐ Patient Portal		☐ Native Hawaiian/Other Pacific Islander
☐ Widowed	☐ E-Mail		☐ White
☐ Life Partner			☐ Other

How would you like us to remind you about your future appointments? (choose one)

☐ Voice Reminder (# we should call) _____

☐ Text message (# we should text) _____ *(Data message rates may apply-contact your carrier)*

☐ E-mail _____

Spouse / Significant Other / Emergency Contact/Support Person

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

How did you hear about us? ☐Employer ☐Family Member ☐Friend ☐Google/Web ☐Insurance Co ☐Previous Patient ☐Referral ☐ Other: _____

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.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Printed Name of Patient/Guardian Date

Acknowledgement of Notice of Health Information Practices

This 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 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 Full 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. (*This is NOT the complete Notice of Health Information Practices. If you would like the full copy it is available by request or by visiting our website at www.fhcsandpoint.com.)*

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

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 POST/Advance Directive? ☐ Yes ☐ No

Do you have a designated Durable Power of Attorney? ☐ Yes ☐ No If yes, who? _____

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		
			Birth Control & Type		
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			
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, and year performed					
☐ *None*					
Surgical Procedure	**Year Completed**	**Outcome of Surgery**	**Surgical Procedure**	**Year Completed**	**Outcome of Surgery**
☐ Appendectomy			***Female Only***		
☐ Back Surgery			☐ Breast Biopsy		
☐ Heart Surgery			☐ Cesarean Section		
Type:			☐ Mastectomy		
☐ Hernia Repair			*Cancerous:*		
Type:			☐ Hysterectomy		
☐ Knee Surgery			*Cancerous:*		
Type:			*If Hysterectomy – what kind?*		
☐ Tonsillectomy			☐ Total, removal of both tubes and ovaries	☐ Total, unilateral of tube and ovary	
Male Only			☐ Radical	☐ Total	☐ Vaginal
☐ Vasectomy					
☐ Other:					

Family History – Check if any family member(s) has had any of the following conditions and age of onset

Are you adopted? ☐ Yes ☐ No

Relationship to you	Alzheimer's	Anxiety	Alcoholism	Asthma	Blood Disorder	Depression	Diabetes	Heart Attack	Heart Failure	Hypertension	High Cholesterol	Renal Disease	Schizophrenia	Stroke	Thyroid Disorder	Cancer – list type and age below	**Alive?** *Mark Yes or No*
Father Age of onset?																	Cause of death and age:
Mother Age of onset?																	Cause of death and age:
Sister(s) Age of onset?																	Cause of death and age:
Brother(s) Age of onset?																	Cause of death and age:

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? _____

Have you/do you use recreational or street drugs? ☐ Yes ☐ No ☐ Previously

If yes, what kind: ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Opioids ☐ Speed ☐ Other _____

How hard is it for you to obtain the very basics like food, housing, heating and medical care?

☐ Very hard ☐ Hard ☐ Somewhat hard ☐ Not very hard

How often do you get together with friends or relatives? _____ times per week/month/year _____ Never

Patient Health Questionnaire (PHQ-9)				
Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching tv				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off any problem on this questionnaire so far, how difficult have these problems made if it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Is there anything else you would like to 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; Emilie Kuster, FNP; Dr. Meulenberg; Dr. Raynor; Dr. J. Waters; Dr. K. Waters

Information to be released:

[ ] Bone Density
[ ] Colonoscopy report & pathology
[ ] Current medication list
[ ] CT Results
[ ] Immunization record
[ ] Last 4 Chart notes
[ ] Last 4 lab results
[ ] Mammogram & pathology
[ ] MRI Results
[ ] Optical Report
[ ] Pap Results

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.