606 N. 3rd Ave Suite 101
Sandpoint, ID 83864
Ph#208.263.1435
Fax# 208.263.4580
www.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!

606 N. 3rd Ave Suite 101
Sandpoint, ID 83864
Ph#208.263.1435
Fax# 208.263.4580
www.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

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!

606 N. 3rd Ave Suite 101
Sandpoint, ID 83864
Ph#208.263.1435
Fax# 208.263.4580
www.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

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 Last Name: _____First Name: _____ Birthdate: _____ Phone:_____ _____

Mother's Address: _____ City: _____ St: _____ Zip: _____

Social Security #: _____ Email Address: _____

Employer's Name: _____ Work Phone: _____

Father's Last Name: _____First 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_____

Preferred Contact	**Ethnicity**	**Race**
☐ Mail	☐ Hispanic/Latino	☐ American Indian or Alaskan Native
☐ Home Phone	☐ Non-Hispanic	☐ Asian
☐ Cell Phone		☐ Black or African American
☐ Patient Portal		☐ Native Hawaiian/Other Pacific Islander
☐ E-Mail		☐ White
		☐ Other

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

☐ Voice Reminder (# we should call) _____

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

☐ E-mail _____

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

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

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

Last Name: _____ First Name: _____ DOB: _____

Reason for today's visit: _____

Preferred Pharmacy: _____

Pregnancy and Birth

(Only fill out if child is currently younger than 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 and age of onset																	
Is child adopted? ☐ Yes ☐ No																	
Relationship to child	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:

Is there anything else you would like to know about your child's 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!