Holmes Family Care

2564 NW Edenbower BLVD Ste126
Roseburg OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

Please note: we must maintain the most up to date and accurate information on our patients. In addition to the face sheet present to you at every visit, we will request that you review and update this form at least once a year.

Date: _____

Patient Information

First Name: _____ M.I: _____ Last Name: _____
SS#: _____ DOB: _____ Sex: _____ Pronouns: _____
Street Address: _____ Apt#: _____ City_____ ST: _____ ZIP: _____
Mailing Address (if different): _____ City: _____ ST: _____ ZIP: _____
Home Phone: _____ Cell: _____ Work: _____
Email: _____
Would you like to be signed up for the portal? O Yes O No

Please Check the boxes below:

Best Contact Method: O Home O Cell O Work O Email O Mail O Portal
By checking one of the boxes of best contact method, I agree to receive correspondence from HFC.
Material Status: O Single O Married O Divorced O Widowed O Separated O Life Partner

Employment Status: O Full-Time O Part-Time O Unemployed O Student O Disabled O Retired

Race: O White O African American O Asian O American Indian/Alaskan Native O Native Hawaiian/Pacific Islander O Declined O Other: _____
Ethnicity: O Non-Hispanic/Latino O Hispanic/Latino O Declined Preferred Language: O English O Spanish O Other_____
Do you have any communication difficulties/special needs? O No O Hearing Impaired O Interpreter required O Reading difficulty O visually impaired O Other: _____

How did you hear about our office: _____

Financially Responsible Party
O Same as patient information (if different, please fill out section below):

First Name: _____ M.I: _____ Last Name: _____
DOB: _____ Relationship: O Spouse O Parent O Guardian O Other:_____
Address: _____ APT#: _____ City: _____ ST: ____ ZIP: _____
Phone: Home: _____ Cell: _____ Work: _____
Email: _____ Employer: _____

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Emergency Contact Notification

Name: _____ Relationship: _____
Phone: Home: _____ Cell: _____

Name: _____ Relationship: _____
Phone: Home: _____ Cell: _____

Contact Detail Information

How would you like to be notified of Normal/Negative Lab/Imaging results? O Phone (ok to leave a voicemail) O Portal O Letter

How would you like to be reminded about appointments? O Text O Phone Call

Do we have permission to leave a detailed Voicemail O Yes O No

Insurance Information

Primary Insurance: _____
ID: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship: O Self O Spouse O Parent O Other: _____
SSN: _____ Employer: _____

Secondary Insurance: _____
ID: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship: O Self O Spouse O Parent O Other: _____
SSN: _____ Employer: _____

Medication Refill Information

Please contact your pharmacy for refills. The Pharmacy will fax us medication request. Refill authorizations may take up to 72 hours to refill so please call before you run out of your medications.

Primary Pharmacy Name: _____ City: _____
Secondary Pharmacy Name: _____ City: _____

Primary Lab

O InterPath O LabCorp O Mercy O Quest

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Pediatric History Form:

Patient Name: _____ DOB: _____
Parent/Guardian Name: _____
Previous PCP: _____ Date of last WCC: _____

Do you vaccinate your child? O Yes O No

How did you find out about our office? _____

Birth History:
O Boy O Girl Birth Weight: ____lbs. _____oz Birth Hospital/State: _____

O Full-term (36wks and up) O Premature (less than 36wks) # of weeks _____

Type of delivery:
O Vaginal O C-section O Forceps O Vacuum

Special interest/hobbies/activities:

Care/Education:
O At Home O Day Care O Pre-school O Elementary O Middle School O High School
O Homeschool

Medical History

Medications:

Medications:	Dose:	Times Per Day:

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Personal Medical History:

Does your child have any history of any medical conditions listed below? (if yes, check next to the condition)

Genetic
O Chromosome Abnormality

Growth:
O Short Stature
O Overweight

Learning:
O Special Education
O Dyslexia

Behavior/Mood:
O ADHD
O Anxiety
O Obsessive-Compulsive
O Depression

Development:
O Delay-speech/language
O Delay- Motor Skills
O Autism

Vision:
O Strabismus
O Amblyopia
O Myopia
O Astigmatism
O Cataract

Hearing:
O Multiple Ear Infection
O Ear Tubes
O Hearing Loss

Other Medical Conditions not listed: _____

Specialty Care:

Has your child ever seen a medical specialist? O Yes O No
If yes, please explain: _____

Please describe any specific concerns you would like to discuss regarding your child:

_____

Surgeries:

Type (specify Left/right)	Date:	Location/Facility:

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Hospitalizations:

Reason:	Date:	Location/Facility:

Household Information:

Please list all those living in the child's home:

Name:	Relationship to Child	DOB:

Are there smokers in the household? O Yes O No
Are there Guns in the household? O Yes O No
Are there Pets in the household? O No O Yes. What kind? _____

Parents relationship status: O Married O Live Together O Divorced O Single Parent O Remarried

If mother and father are not living together or if the child does not live with parents, what is the child's custody status?

_____

_____

_____

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Family History:

Name: _____ DOB: _____

Family Members	Statues: (Alive or Deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer	Mental Illness
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Brother(s)								
Sister(s)								
Son(s)								
Daughter(s)								