Mercer Island Community Family & Internal Medicine Clinic: New Patient Intake Form

Today's Date (MDY) / /

LastName		**First**	**Middle**
Birth Gender	Circle one Male Female	**Assigned gender if different**:	
Birthdate	Month Day Year		**Today's age**
Cell #		To receive appointment reminders, weather cancellations, and other visit related notices. Test results will not be left on voicemails nor sent via email	
Email			
Address If mailing address different, please also list			

Country of Birth_____ **Countries you lived in for long than 7weeks**_____

How did you hear about us? Please circle all applicable Walked by Internet Referred by:_____

Allergies to Medications _____

Allergies, other: _____

Past Medical History Please circle all issues and note year issue started

	Year		**Year**		**Year**
Asthma		Heart Problems		Skin Problems	
Bladder or Prostate		High Blood Pressure		Sleep problems, more than 2x/wk	
Brain Injury		High blood sugar		Others	
Broken bones		Kidney Problems			
COPD/Emphysema		Liver problems			
Ear Problems		Lung Problems			
Eye Problems		Muscle Problems			

Medications & Supplements you use at least once a week_____

_____

Humans are social and those around us help us stay healthy. The information below helps us take better care of you

a. Who do you live with more than once a week? Please note more members in another page if needed

First Name/Last Name	**Gender**	**Relation**	**Current Age**

b. Who are your close adult friends and/or relatives? Please note more members in another page if needed

First Name/Last Name	**Gender**	**Relation**	**Age**	**City/State**

Anything else you wish to share that may affect our care for your health? (eg. Afraid of needles, nausea with antibiotics)

_____

You authorize us to discuss your medical concerns with the adult (+18yo) below if you are not available: Leave blank if none

Last Name _____ First Name _____ Phone number _____

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Mercer Island Community Family & Internal Medicine Clinic

Medical Care, Privacy and Financial Policies Agreement

Patient's Last Name	**First Name**	**Age**

If patient is under 18 years old or in care of a guardian, below is guardian who will usually accompany patient and is signing below. If there are more guardians, please provide information separately.

Guardian Last Name	**Guardian First Name**
Age	**Relation to Patient**
Cell phone	**Home Phone**
If lives at different address, please list address	
If patient is 18years or older, please list reason(s) guardian is needed	

Agreement of Mutual Responsibility and Understanding of the Limits of Medicine

The undersigned or patient's guardian hereby authorizes Community Family and Internal Medicine, LLC, to provide medical care. Dr. Fang pledges to provide the most appropriate medical care possible. Patient and any guardians will in turn provide all necessary information and cooperate with medical advice. Patient and guardians understand that disease processes may vary in presentation due to timing and person to person variability. Long term relationship and timely follow up can decrease missed diagnoses and/or allow a change in treatment plan in a timely manner

Privacy Dr. Fang takes your privacy seriously and complies to the best of her ability to privacy requirements as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), enforced by the US Department Health and Human Services (hhs.gov/hippa). Please note if someone is within earshot when you are discussing medical issues (eg.you bring a friend into the exam room), it is assumed that you are waiving your privacy in those instances.

- *If you email/text the clinic, you may get a reply even if you may not have secured/HIPPA compliant email/text.*

*If you **do not want** to receive non-secured email or text, please sign here* _____

Alternatives include communicating by HIPPA compliant Fax and by phone. Communication with referring or referred health care providers do not require consent.

Financial Policy You agree to pay by credit/debit/Flex/HSA card or cash at the end of your appointment. This practice does not bill insurance/Medicare/Medicaid. Upon request, receipts or itemized bills (2 clinic business days) are available.

- *Upon request, the clinic may email you itemized bill with your treatment and procedure diagnosis even if you may not have secured/HIPPA compliant email.*

*If you **do not want** to receive non-secured email with itemized bill, please sign here* _____

Medical records are charged at $0.25 per page and will be available only for in person pickup by patients/guardians. Records not from the same business day may require 2 clinic business days to be copied. You may take free pictures of your records in person. Please email ahead to schedule a time.

I agree with the above and acknowledge I have either received a copy of this form and HIPPA privacy notice or have declined. I may revoke my agreement anytime in writing by mail or email to fang@mecerfamilymed.com

Signature _____ Print Name if Guardian Signing _____