Darlena Pike, FNP-C
1201 NE 7th Street, Suite E
Grants Pass, Or 97526
Phone (541) 314-4894
Fax (541) 314-4895
QualityLifeFamilyPractice.com

New patient Information

Patient Information	
Name (last, first, middle initial)	Date of birth Gender M F
Mailing Address	Phone number (home/cell) Preferred contact method OK to leave message? Y N
Email address:	
Social Security No:	Marital Status (circle) Single Married Divorce Widow Partnered Separated
Preferred pharmacy:	

Insurance Information	
Primary Insurance Policy number Group number	Secondary Insurance (if applicable) Policy number Group number

In case of Emergency
Name of contact Relationship Phone number

Referral Source
We would appreciate learning who you were referred by

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The following questions are strictly voluntary and used for Meaningful Use purpose

Race: ☐ Declined ☐ American Indian/Alaska Native ☐ Black/African American ☐ Nat Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Other

Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Past Medical History

If you have had any of these medical problems, please circle.

Anemia
Anxiety
Angina (chest pains)
Asthma
Arthritis/Osteoarthritis
Back pain
Bipolar disorder
COPD/emphysema
Cough (chronic)
Chronic Pain
Deep Vein Thrombosis
Dementia
Depression
Diabetes Type I or II

Edema
Hearing Loss
Heart Attack
Hepatitis
High Cholesterol
High blood Pressure
Insomnia
Kidney Disease
Liver Disease
Osteoporosis
Seizure Disorder
Stroke or TIA's
Urinary concerns
Vertigo/dizziness

Vision loss

Cancer: Please list
____
____
____
____

Males:
Prostate issues

Females:
Menstrual problems
Uterine fibroids

Other medical problems not listed above ____
____

Females:

LMP ______________________ Contraception _________________________
Pregnancies _____ Live births ____ Abortions _____ Miscarriages ______
Last Mammogram _________________________

Are you followed by any specialists? ____

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Medications

Medication	Dosage	Frequency

Supplements: ______________________________

____

____

Allergies: ______________________________

____

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Past Surgical History

If you have had any of these surgical procedures, please circle and write in date.

Appendix	Hernia Repair
Amputation	Hysterectomy
Back Surgery	Laparoscopic (diagnostic)
C- Section	Mastectomy
Cardiac surgery	Melanoma Removal
Carpal Tunnel Release	Skin cancer biopsy
Endoscopy	Tonsillectomy
Gall Bladder	Prostate surgery

Other operations, please list with date: ______________________________

____

____

Family Medical History

Has any blood relative had any of the following problems? List relationship.
Only include parents, grandparents, and siblings.

Alzheimer/Dementia ______________________________
Anemia ______________________________
Cancer (type) ______________________________
Diabetes, Type I or II ______________________________
Heart Disease ______________________________
High blood pressure ______________________________
Kidney disease ______________________________
Liver disease ______________________________
Mental Health Issues (type) ______________________________
Osteoporosis ______________________________
Stroke ______________________________

Other family medical problems not listed. ______________________________

____

____

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Social History

Smoking history: yes no

Current use (packs per day) ____________ Past use: (When quit) __________________

Alcohol – current use _________________ Average use in past ___________________
Do you consider yourself an alcoholic __________

Recreational drugs (past or present) ____

Employment:
☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Retired
Employer ____

Do you have any hobbies? What do you like to do for fun? ______________________________
____
____
____
____

Is there anything else you would like to add so that we may get to know you better?

____ ________________________
Signature Date Completed

RELEASE OF INFORMATION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: ____

Name Address

Previous health care provider/entity disclosing information to use and disclose a copy of the specific health information described below regarding:

____

Patient Name Date of Birth

consisting of medical record including lab and imaging to:

Quality Life Family Practice, LLC 1201 NE 7th Street, Suite E Grants Pass, Oregon 97526 Phone 541-314-4894 Fax 541-314-4895

For the purpose of continuing health care.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

____________ HIV/AIDS Information
____________ Mental Health Information
____________ Genetic Testing Information
____________ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information and drug/alcohol diagnosis, treatment or referral information.

____

Signature of Individual or Personal Representative Date

ORS 192.566 AUTHORIZATION FORM

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information describe above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, send a written statement to:

Quality Life Family Practice, LLC
1201 NE 7th Street, Suite E
Grants Pass, Oregon 97526

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires:
______________________________ (Insert either applicable date or event).

____

Signature of Individual or Personal Representative   Date

Description of personal representative's authority: