Bonners Ferry Family Medicine

6488 Chinook, Bonners Ferry, ID 83805 Phone - (208) 267-8710

Contact Information

The information provided will not be release unless written consent is provided by the patient, except as required by law. We must report suspicion of child/elder abuse, reportable sexually transmitted diseases with positive results, and information required by court order.

Patient: *Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other*_____

Last Name_____ First Name_____ Middle_____ M / F

Date of Birth_____Age_____SS#_____

Home Ph#_____Cell#_____Alt#_____

Mailing Address_____City_____State_____Zip_____

Physical Address_____City_____State_____Zip_____

E-Mail Address_____

Employment: ____*Full Time* ____*Part Time* ____*Seasonal* ____*Unemployed* ____*Self Employed* ____*Retired* ____*Disabled* ____*Student*

Employer_____Occupation_____Wk#_____

Address_____City_____State_____Zip_____

Emergency Contact: *Spouse ☐ Parent ☐ Guardian ☐ Other*_____

Last Name_____ First Name_____ Middle_____ M / F

Mailing Address_____City_____State_____Zip_____

Date of Birth_____SS#_____Phone#_____

Relationship to Patient_____

I authorize Bonners Ferry Family Medicine to disclose information to:

Spouse: _____ Phone # _____

Child: _____ Phone # _____

Parent: _____ Phone # _____

Caregiver: _____ Phone # _____

Insurance or Medical Plan Information:

Self Pay ☐ Medicare ☐ Medicaid ☐ Other Insurance ☐

Primary: _____ID#_____GRP#_____

Name of Policy Holder_____DOB_____Relationship_____

Is there a copay? ___Yes ___No Amount $_____ Effective Date_____

Secondary: _____ID#_____GRP#_____

Name of Policy Holder_____DOB_____Relationship_____

Is there a copay? ___Yes ___No Amount $_____ Effective Date_____

Assignment of Insurance Benefits

I hereby authorize Bonners Ferry Family Medicine to request on my behalf, and to collect directly, all public and private insurance coverage due for products and services supplied. In the event that insurance benefits are paid directly to me, I will endorse to Bonners Ferry Family Medicine all checks for such payments. I also authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating claims for insurance benefits.

I hereby agree that I am financially responsible for all charges incurred for services provided.

Medical and Surgical Consent: The undersigned hereby consents to medical treatment, which may include laboratory, medication and/or x-ray procedures that the physician may order.

_____ _____ _____

Signature Parent/Guardian (if minor) Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Bonners Ferry Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Bonners Ferry Family Medicine describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bonners Ferry Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bonners Ferry Family Medicine.

With this consent, Bonners Ferry Family Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Bonners Ferry Family Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request that Bonners Ferry Family Medicine restrict how it uses or discloses PHI to carry out TPO. The practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Bonners Ferry Family Medicine to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Bonners Ferry Family Medicine may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____

Print Name of Patient or Legal Guardian, if applicable

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Initial History Questionnaire for Children

Patient Name:_____Birth Date_____Age_____

Form Completed by_____Date Completed_____

Household:

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

Name:	Relationship to child	Birth Date	Health Problems

Are there siblings not listed? If so, please list names and ages and where they live:

_____

_____

_____

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

_____

Birth History

Birth weight_____

Was the baby born at term?_____Early?_____Late?_____

If early, who many weeks gestation?_____

Did mother have any illness or medical condition?_____

If yes, please explain_____

During pregnancy, did mother:

Drink Alcohol? YES NO Smoke? YES NO

Use drugs or medications? YES NO

If yes, What_____When_____

What type of delivery? Vaginal Cesarean

If cesarean, why?_____

Did your baby have any problems immediately following birth? YES NO If yes, please explain

_____

_____

Was initial feeding: Breast Bottle Both

Did your baby go home with his/her mother from the hospital? YES NO if NO, please explain

_____

General

Do you consider your child to be in good health? YES NO If no, explain_____

Does your child have any illness or medical condition? YES NO If yes, explain_____

Has your child had serious injuries or accidents? YES NO If yes, explain_____

Has your child had any surgery? YES NO If yes, explain_____

Has your child ever been hospitalized? YES NO If yes, explain_____

Is your child allergic to any medicines or drugs? YES NO If yes, explain_____

Do your immunize your child? YES NO If no, explain_____

Development

Are you concerned about your child's physical development? YES NO

Are you concerned about your child's mental or emotional development? YES NO

Are you concerned about your child's attention span? YES NO

If your child is in school, how is his/her behavior in school?_____

Has he/she failed or repeated a grade in school? YES NO

How is he/she doing in academics subjects?_____

Is he/she in special or resource classes? YES NO

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Family History *Have any family members had the following?*

Deaf	YES	NO	Who?_____Comments_____
Nasal allergies	YES	NO	Who?_____Comments_____
Asthma	YES	NO	Who?_____Comments_____
Tuberculosis	YES	NO	Who?_____Comments_____
Heart disease (before age 50)	YES	NO	Who?_____Comments_____
High blood pressure (before age 50)	YES	NO	Who?_____Comments_____
High Cholesterol	YES	NO	Who?_____Comments_____
Anemia	YES	NO	Who?_____Comments_____
Bleeding disorders	YES	NO	Who?_____Comments_____
Liver disease	YES	NO	Who?_____Comments_____
Kidney disease	YES	NO	Who?_____Comments_____
Diabetes (before age 50)	YES	NO	Who?_____Comments_____
Bed-wetting (after age 10)	YES	NO	Who?_____Comments_____
Epilepsy or convulsions	YES	NO	Who?_____Comments_____
Alcohol abuse	YES	NO	Who?_____Comments_____
Drug abuse	YES	NO	Who?_____Comments_____
Mental illness	YES	NO	Who?_____Comments_____
Intellectual Disability	YES	NO	Who?_____Comments_____
Immune problems, HIV or AIDS	YES	NO	Who?_____Comments_____

Additional family history:_____

Past history *Does your child have, or has he/she ever had*:

Chicken pox	YES	NO	When_____
Frequent ear infections	YES	NO	Explain_____
Problems with ears or hearing	YES	NO	Explain_____
Nasal allergies	YES	NO	Explain_____
Problems with eyes or vision	YES	NO	Explain_____
Asthma, bronchitis, bronchiolitis or pneumonia	YES	NO	Explain_____
Any heart problem or heart murmur	YES	NO	Explain_____
Anemia or bleeding problem	YES	NO	Explain_____
Blood transfusion	YES	NO	Explain_____
Frequent abdominal pain	YES	NO	Explain_____
Constipation requiring doctor visit	YES	NO	Explain_____
Bladder or kidney infection	YES	NO	Explain_____
Bed-wetting (after 5 years old)	YES	NO	Explain_____
(For girls) Has she started menstruating	YES	NO	Explain_____
(For girls) Are there problems with her periods	YES	NO	Explain_____
Any chronic or recurrent skin problems	YES	NO	Explain_____
Frequent headaches	YES	NO	Explain_____
Convulsions or other neurological problem	YES	NO	Explain_____
Diabetes	YES	NO	Explain_____
Thyroid or other endocrine problem	YES	NO	Explain_____
Any other significant problems	YES	NO	Explain_____
Use of alcohol or drugs	YES	NO	Explain_____

Signature of parent or guardian_____Date_____

Signature of Physician_____Date_____