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 & Primary Authorized 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 health care services that the health care provider may order which may include diagnosis, laboratory, screening, examination, x-ray procedures, prevention, medication, treatment, cure, or relief of any physical or mental health condition, illness, injury, defect.

_____ _____ _____
Signature Parent/Guardian (if minor) Date

Bonners Ferry Family Medicine

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 or text 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, email or text 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.

_____

Print Patient's Name

_____

Print Name of Patient or Legal Guardian, if applicable

_____ _____

Signature of Patient or Legal Guardian Date

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HEALTH HISTORY

Patient Name:_____DOB:_____Date:_____Pharmacy: _____

Family History:

Family Member	Age(s)	Living	Cause of Death
Father			
Mother			
Brother(s) #			
Sister(s) #			

Diseases in the FAMILY: *(Check all that apply)*

- ☐ Arthritis
- ☐ Addiction problems
- ☐ Bleeding problems
- ☐ Depression/Anxiety
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Prostate cancer
- ☐ Other cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental Illness

Social History:

Do you live: ☐ Alone ☐ with Spouse or Partner ☐ with Family ☐ Other
Who do you rely on for support and help? _____
Do you smoke? ☐ Currently ☐ Past ☐ Never _____packs/day for _____ years Date quit: _____
If you do smoke, are you interested in quitting? ☐ YES ☐ NO
Other nicotine use? ☐ YES ☐ NO
Exposure to second hand smoke? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? _____
How many caffeinated beverages per day? _____ ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements
Any recreational drug use? ☐ YES ☐ NO Type: _____
Do you exercise regularly? ☐ YES ☐ NO If so, how many times per week? _____ Type of exercise: _____
Do you feel safe in your home? ☐ YES ☐ NO
How many hours of sleep do you get per night? _____ Do you wake feeling well rested? ☐ YES ☐ NO

Current Medications	Dosage / How often	Disease or Reason	Prescribed by

List of all medications you have stopped taking in the last 12 months: _____
_____

Allergies (Medication/Food/Environmental)	Reaction

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Name:_____ DOB: _____

Past Medical History:

- ☐ Acid reflux
- ☐ Alcohol or Drug problem
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery/vein problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Crohns
- ☐ Chronic pain
- ☐ Stroke
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Esophagitis/Ulcers
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ TB
- ☐ Irritable bowel
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease/Hepatitis
- ☐ Lung disease
- ☐ Migraines
- ☐ Mental health diagnosis
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Sleep apnea
- ☐ Thyroid disease

Other diseases not listed above: _____

Hospitalizations/Significant injuries: _____

_____

Surgery/Procedures History: *(check all that apply)*

- ☐ Appendix
- ☐ Bladder suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Colon/Rectal surgery
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Hernia
- ☐ Heart surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
  - ☐ Pacemaker
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial
- ☐ Orthopedic surgery
- ☐ Joint replacement
- ☐ Kidney surgery
- ☐ Organ transplant
- ☐ Prostate surgery
- ☐ Thyroidectomy
- ☐ Sinus surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal ligation
- ☐ Vasectomy

Other surgery not listed above: _____

Previous reaction to anesthesia: *(explain)* _____

_____

Please list the names of the other practitioners you have or are currently seeing: _____

_____

Patient Signature:_____Date:_____