



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



Bonners Ferry Family Medicine

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 you 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
Mental retardation	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 _____