Swofford & Halma Clinic, Inc. P.S.

NEW PATIENT INQUIRY SHEET

Today's Date/Fecha de hoy: _____

Patient's Name/Nombre del paceinte: _____

Date of Birth/Fecha de naciemiento: _____

Phone Number/Numero de telefono: _____

Is there anyone in your immediate family who is a patient with our clinic? Yes or No /Hay alguien en su familia immediata que sea paciente con nuestra clinica? Si o No

If so, patient's name/Si es asi, el nombre por forvor: _____

Any medical problems acute or chronic/Cualquier problema de salud ayudo o chronico?

_____

_____

Current medications including those you take as needed/Las medicamentos actuales incluyendo lo que usted toma por necesidad:

_____

_____

IT IS IMPORTANT THAT YOU BE AWARE THAT OUR PROVIDERS DO NOT PROVIDE PAIN MANAGEMENT TO PATIENTS/ES IMPORTANTE QUE USTED ESTE ENTERADO QUE NUESTROS PROVEEDORES NO MANEJAN DOLOR CHRONICO EN LOS PACIENTES

Have you been seen in any clinic, hospital, or Medi-Centers? If so, which one?/Ha sido visto en cuelquier clinica, hospital, centros medicos? Se ese es el caso cual?

_____

Reason for transfer/Motivo de la transferencia: _____

_____

Type of insurance/Tipo de aseguransa: _____

How did you hear about our clinic?/Como se entero de nuestra clinica? _____

_____

Preference of doctor/La preferencia del medico?

Dr. Halma Dr. Bond Marivel Sandoval, PA-C Ramon Perez Jr, PA-C Maricela Ramirez, PA-C
Margaret Kranz, PA-C Bristol Fletcher, ARNP

I certify that this information is correct and true, if found to be incorrect or false this may affect your acceptance to our clinic./Certifico que esta informacion es correcta y verdadera, si encontramos ser inexact o falsa esto puede efectar aceptacion a nuestra clinica.

X _____ Date _____

SWOFFORD & HALMA CLINIC, INC. P.S.

FAMILY PRACTICE

Harlan D. Halma, M.D. · Blake Bond, MD · Marivel Sandoval, PA-C · Margaret Kranz, PA-C

Ramon Perez Jr, PA-C · Maricela Ramirez, PA-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____
Date of Birth_____
Social Security #_____

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION RELEASED TO:
Swofford & Halma Clinic, Inc.
2303 Reith Way
PO Box 119
Sunnyside, WA 98944

INFORMATION TO BE SENT FROM:
_____
_____
_____

Purpose: _____Possible Transfer of Care _____ OB Care _____Other/Self

_____ Newborn-present _____ 2016- Present

The following records are requested for release: _____ All Medical Records _____Progress Notes _____ Lab & X-rays

_____Prenatal History _____Pap Smear _____Ultrasound _____Immunization Record

___/___/___ _____ _____
Date SIGNATURE OF PATIENT OR OR PATIENT'S AUTHORIZED REP. RELATIONSHIP

___/___/___ _____ _____
Date SIGNATURE OF WITNESS TITLE

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis, and treatment for:

_____HIV/AIDS _____Sexually transmitted diseases _____Psychiatric treatment _____Alcohol/drug use

_____Mental illness

I understand that I do not have to sign this authorization in order to get health benefit (treatment, payment, enrollment or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that: A) I must revoke my authorization in writing and do so by completing and signing the Revocation of Authorization Form available at Swofford & Halma Clinic (SHC); B) If I revoke my authorization, it will not affect any actions already taken by SHC based upon this authorization, and C) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once SHC has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than 90 days after the date of this authorization. This prohibition does not extend to insurance companies.

This authorization will expire 90 days from the date of signature. *** This is not a transfer of care; patient's application is in the process of being reviewed. *****

___/___/___ _____ _____
Date SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REP. RELATIONSHIP

Swofford and Halma Clinic, Inc. P.S.
Health Questionnaire

Please provide information which will help construct a complete health record plan.

Name: _____ Age: _____ Date: _____

What medications are you taking regularly?

Name:	Dose:	Name:	Dose:

Are you allergic to any medication or foods? Please list:

Preferred Pharmacy: _____

List any surgeries: (Example: appendix, gallbladder, hysterectomy, ect.)

Name:	Date:	Hospital:

List any major illnesses (diabetes, high blood pressure, heart trouble, chronic lung problem, cancer):

Name:	Date Diagnosed:	Name:	Date Diagnosed:

List serious injuries:

What happened:	Date:	Hospital:

Vaccinations

Have you completed all of the usual childhood immunizations (diphtheria, tetanus, whooping cough, oral polio, measles, mumps, and rubella)? _____

When was your last tetanus booster? _____

Do you usually receive a yearly influenza ("flu") shot? _____

If you work in a health care facility or institution, have you received hepatitis B vaccination? _____

Family Medical History:

	How Many:	Age(s):	Deceased:	Illness:
Mother:		_____	_____	_____
Father:		_____	_____	_____
Brother(s):	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____
Children(s)	_____	_____	_____	_____

List any family members with cancer:

Relationship:	Type of cancer:	Relationship:	Type of cancer:
_____		_____	
_____		_____	

Personal History:

Present marital status? _____ Religious preference? _____

Occupation: _____ Spouses occupation? _____

Hobbies or Interest: _____

Healthy Habits:

Recreacional Drug (i.e.; marijuana, cocaine, etc) _____

Do you smoke? _____ Packs per day_____ Duration (how long) _____yrs

Do you drink? _____ (Wine___ Beer___ Mixed Drinks___)

How much alcohol do you consume on a regular basis? _____

Do you drink caffeine (soda, coffee, energy drinks)?_____ How many?_____

Do you exercise (walk, jogging, biking, etc.)? _____

Do you take or obtain alternative medicine (chiropractor, massage, herbal, ect.)? _____

_____

Do you have financial or stressful family problems which may be affecting your health?

_____

Obstetrical History (women only)
Dates of Pregnancies and Deliveries: _____

_____

Have you had any miscarriages or abortions? _____

What birth control method are you using? _____