NEW PATIENT INQUIRY SHEET

Today's Date / Fecha de hoy: _____

Patient's Name/Nombre del paciente:_____

Date of Birth/Fecha de Nacimiento:_____

Phone Number/Numero de Telefono:_____

Are you currently Pregnant? _____

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

If so name/ Si es asi, el Nombre por favor: _____

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

_____

_____

Current medications you are taking / Los medicamentos que esta tomando actualmente:

_____

_____

IT IS IMPORTANT THAT YOU BE AWARE THAT OUR PROVIDERS DO NOT PROVIDE PAIN MANAGEMENT TO PATIENTS/ ES IMPORTANTE QUE USTED ESTE INFORMADO QUE NUESTROS PROVEEDORES NO MANEJAN DOLOR CRONICO.

Have you been seen in any clinic, hospital, or Medi-Center? If so, which one? Ha sido visto en cualquier clinica, hospital, centros medicos? Si este 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?_____

_____

Circle preferred Provider? / Circule su Proveedor Preferido?

Dr. Halma Dr. Bond Margaret Kranz, PA-C Maricela Ramirez, PA-C

Ramon Perez, PA-C Ismael Vargas,PA-C Danna Micech, FNP-C Tenille Draper, PA-C

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 que es incorrecta o falsa esto puede afectar aceptacion a nuestra clinica.

X_____ Date_____

SWOFFORD & HALMA CLINIC, INC. P.S.

FAMILY PRACTICE

Harlan D. Halma, M.D. · Blake Bond, MD · Marisela Ramirez , PA-C · Margaret Kranz, PA-C

Ramon Perez Jr, PA-C * Ismael Vargas, PA-C * Danna Micech, FNP-C * Tenille Draper, 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 & Halma Clinic, Inc. P.S.
Health Questionnaire

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

Name: _____ Today's Date: _____ Date of birth:_____

What medications are taking regularly?

Name:	Dose:	Name:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

_____

_____

Preferred pharmacy: _____

List any surgeries: (Examples: appendix, gallbladder, hysterctomy, etc.)

Name:	Date:	Hospital:
_____		
_____		

List any major illnesses: (Examples: diabetes, high blood pressure, heart trouble, chonic 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 (diptheria, 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: _____ Spouse's occupation: _____

Hobbies or interests: _____

Health Habits:

Recreational drug(s)? (i.e.: marijuana, cocaine, etc) _____

Do you smoke? _____ Packs per day: _____ Duration (how long)_____ years

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, acupunture, herbal, etc)? _____

_____

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? _____