



**New Patient Packet – Family Practice Clinic**

**Patient Information**

*\*\*This is protected health information\*\**

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Legal Sex Assigned at Birth:  Male  Female Pronouns: \_\_\_\_\_

Gender:  Male  Female  Non-binary  Transgender Female  Transgender Male  Other \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email: \_\_\_\_\_ Patient Portal?  Yes  No

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Other Demographics**

Language: \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White  Declines to answer  Other: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declines to answer

**Emergency Contact**

First & Last Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Communication Preferences**

How do you prefer to receive verbal communication from us? Please check what applies to you.

	Call which phone	Okay to leave message?
Appointment Information	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Information from your Provider	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Financial Information	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

Please write the phone number you would like us to use for Appointment Reminders: \_\_\_\_\_

Would you like to receive text message reminders?  Yes  No



# CASCADE MEDICAL

PARTNERS IN YOUR HEALTH

**Insurance Guarantor (if different from patient)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Briefly state your main concerns with your health**

**Other Providers Currently Treating You, Including Specialists**

Name of Provider	Facility	Contact Information

Preferred Pharmacy & Location: \_\_\_\_\_

Please list all allergies and adverse reactions to medication and foods and the reaction you experienced

Allergy / Adverse Reaction	Reaction

Please list all medications that you are currently taking including supplements, ointments, and herbs along with the dose of the medication and how often you take it.

Name of Medication	Dose & How Often You Take the Medication



**Medical History**

Please list your medical problems and the approximate month and year it began

Condition	Month and Year Began

Please list any surgeries, injuries, and hospitalizations with approximate date

Surgery/ Injury/ Hospitalization	Date

**Family History Medical Problems**

Relative	Living	Age or Age at Death	Please list any health problems
Parent 1	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Parent 2	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No		



# CASCADE MEDICAL

PARTNERS IN YOUR HEALTH

## Reproductive Health History

Age of first period: \_\_\_\_\_ Age of menopause if applicable: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Results: \_\_\_\_\_ Facility where completed: \_\_\_\_\_

History of abnormal pap smear: Yes No History of birth control: Yes No

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

History of ectopic pregnancies: Yes No History of sexually transmitted diseases: Yes No

History of reproductive organ cancer: Yes No History of infertility: Yes No

History of exposure to environmental or occupational toxins: Yes No

## Immunizations

Are you needing immunizations updated? Yes No

Which immunizations are you needing? \_\_\_\_\_

## Preventive Care

If you have had the screenings below, please document the date of the last screening and the location where it was completed.

Screening	Date of Last Screening	Location of Last Screening	Results
Mammogram			
Pap Smear			
Bone Density (DEXA)			
Abdominal Aneurysm (AAA)			
Eye Exam			
Colonoscopy			
Stool FIT Test			
Cologuard			
Hepatitis C Screening			
HIV Screening			
Genetic Testing			

## Social, Educational, and Work History

Are you a current smoker? Yes No If yes: What age did you start: \_\_\_\_\_

Are you a former smoker? Yes No If yes: What year did you quit: \_\_\_\_\_

How many packs per day did/do you smoke? \_\_\_\_\_

How many ounces of alcohol do you drink per day? \_\_\_\_\_ What type(s)? \_\_\_\_\_

Do you use recreational drugs? Yes No If yes, which ones and frequency? \_\_\_\_\_



## Social Determinants of Health Screening Questionnaire

### Living Situation

1. What is your current living situation?
  - I presently have a place to live
  - I have a place to live at present, but am concerned about future
  - I presently do not have a place to live
2. Problems where you live?
  - Pests, such as bugs, ants, or mice
  - Mold
  - Lead paint or pipes
  - Lack of heat
  - Oven or stove not working
  - Smoke detectors missing or not working
  - Carbon monoxide detectors missing or not working
  - Water leaks
  - Unsafe flooring/stairs
  - Inadequate lighting
  - No known problems

### Utilities

1. In the past 12 months, have your utilities been in danger of being shut off?
  - Yes
  - No
  - Already shut off

### Transportation

1. In the past 12 months, have you had a lack of transportation that kept you from medical appointments, meetings, work, or getting things needed for daily living?
  - Yes
  - No

### Financial Stress

1. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
  - Very hard
  - Hard
  - Somewhat hard
  - Not very hard
  - Decline to answer
  - Not applicable



**Food**

1. In the past 12 months, have you feared food would run out before you were able to buy more?
  - Often true
  - Sometimes true
  - Never true
2. In the past 12 months, food didn't last until you had money to buy more.
  - Often true
  - Sometimes true
  - Never true

**Employment**

1. Do you want help finding or keeping work or a job?
  - Yes, help find work
  - Yes, help keeping work
  - I do not need or want help

**Personal Safety – Other Abuse**

1. How often does anyone, including family, friends and others, physically hurt you?
  - Never
  - Rarely
  - Sometimes
  - Frequently
  - Often
  - Declined to answer
2. How often does anyone, including family, friends and others, insult or talk down to you?
  - Never
  - Rarely
  - Sometimes
  - Frequently
  - Often
  - Declined to answer
3. How often does anyone, including family, friends and others, threaten you with harm?
  - Never
  - Rarely
  - Sometimes
  - Frequently
  - Often
  - Declined to answer
4. How often does anyone, including family, friends and others, scream or curse at you?
  - Never
  - Rarely (**continued on next page**)



# CASCADE MEDICAL

PARTNERS IN YOUR HEALTH

- Sometimes
- Frequently
- Often
- Declined to answer

## Personal Safety – Firearms

1. Firearms in the home?

- Yes
- No
- Unknown
- Declined to answer

Over the **LAST TWO WEEKS**, how often have you been bothered by any of the following problems?

	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Feeling afraid, as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1. Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<p>If you checked off ANY problems, how DIFFICULT have these problems made it for you to do your work, take care of things at home, or get along with other people?</p> <p>           Not difficult at all      Somewhat difficult      Very difficult      Extremely difficult         </p> <p> <input type="checkbox"/>                      <input type="checkbox"/>                      <input type="checkbox"/>                      <input type="checkbox"/> </p>				



## Consent for Medical Care

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Release of Information:* Cascade Medical (CM) may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to CM or to the patient for all or part of CM's charges, including but not limited to, insurance companies, government health agencies, workman's compensation and/or employers.

*Financial Responsibility and Assignment of Insurance Benefits:* I hereby authorize payment directly to CM for CM's benefit otherwise payable to me, but not to exceed CM's regular charge for this period of service. I understand that I am financially responsible to CM for charges not paid under this assignment. Should the account be referred to a collection agency for collection, I the undersigned shall pay collection expenses and reasonable collection and attorney's fees.

I further authorize CM to make such inquiry as it determines necessary to confirm any coverage and my financial responsibility, from any third party payor or financial references I may have named, and I hereby authorize those payors and/or references to release such information to CM.

Even though an insurance claim may be pending, I understand I may receive a statement each month if my account has an outstanding balance. I further understand that CM cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for the timely payment of my account, and for all delinquency charges resulting from a failure to timely pay that account.

The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself to pay the account, as well as obligating the patient, and CM may look to either or both for payment.

If insurance card is not available, please initial as applicable:

\_\_\_\_\_ I will fax/mail or bring my card to CM

\_\_\_\_\_ I understand that until I bring my card, I will be billed

*Consent for Medical Care:* I hereby agree that the patient is under the control of his/her healthcare provider and the undersigned consents to any treatment of hospital/clinic service rendered to the patient under the general and special instruction of his/her healthcare provider.

*Medicare Patients: Patient's Certification, Authorization to Release Information and Payment Request:* I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries, or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits to be made on my behalf.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

---

**Refusal to Sign: Patient refuses to sign this document.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Receptionist

\_\_\_\_\_  
Witness



# AUTHORIZATION TO RELEASE or REQUEST HEALTHCARE INFORMATION



**CASCADE MEDICAL**  
PARTNERS IN YOUR HEALTH

Patient Legal Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Former Name(s): \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

I request and authorize CASCADE MEDICAL at 817 Commercial Street, Leavenworth, WA 98826 to  **Release** OR  **Request** my healthcare information to the entity(s) below (if more than 2 entities please use back of form to add more):

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip Code: \_\_\_\_\_

**OR Release to Self via Mail or Lobby Pick-up (circle one) OR email:** \_\_\_\_\_

Print clearly

## Healthcare information to be released or requested:

**Date range** \_\_\_\_\_ **Types of Records:**  Emergency Room Record  Lab Reports(s)  
 Immunizations  Provider Office Notes  Diagnostic Images & Reports  Inpatient Records (includes Discharge Summary, History and Physical, Operative / Procedure Report(s))  Consultations  Colonoscopy & Path  EKGs - **ALL**  
 PAP & Path Reports - **ALL**  PT/OT/ST  Billing Records  Other: \_\_\_\_\_

**Records with special protection:** State and federal laws protect certain healthcare information. I understand that unless otherwise indicated or specified here, a request for disclosure or release of healthcare information/records may include information regarding the diagnosis and/or treatment of HIV (AIDS virus), other sexually transmitted infections, drugs and/or alcohol abuse, behavioral health, mental illness or psychiatric treatment, sexual abuse or assault, domestic violence, genetic information, adoption information, social service records, communications made to a social worker.

If this information applies to you, you **must** check **YES** or **NO** if you would like this information released:

Alcohol, Drug or Substance Abuse Records  Yes  No

HIV/AIDS Testing and Results  Yes  No

Mental Health, Psychotherapy Records  Yes  No

## By signing this authorization, I understand that:

- Requests for copies of medical records are subject to reproduction fees, in accordance with federal/state law. I have the right to cancel this authorization at any time. Cancellation must be made in writing and presented or mailed to Cascade Medical at 817 Commercial Street, Leavenworth, WA 98826. Cancellation will not apply to information/records already issued in response to this authorization. Cascade Medical is not responsible for any unauthorized re-disclosure of my healthcare information by others including the person or facility receiving the records requested in this authorization.
- This authorization will expire one year from the date signed unless I cancel before that time. I am not required to sign this authorization. I may have a copy of this authorization at my request. I understand the use of email is at my own risk.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient's legal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

*For CM Use ONLY*  
Date completed: \_\_\_\_\_  
Initials: \_\_\_\_\_  
ID Check: \_\_\_\_\_



**CASCADE MEDICAL**  
PARTNERS IN YOUR HEALTH

817 Commercial Street, Leavenworth, WA 98826 • phone: 509-548-5815 • fax: 509-548-1605

## Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, hereby acknowledge that I have received a copy of the Cascade Medical Center Notice of Privacy Practices.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative, etc.)