CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

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	☐ Cell ☐ Home ☐ Work	☐ Yes ☐No ☐ Yes ☐No ☐ Yes ☐No
Information from your Provider	☐ Cell ☐ Home ☐ Work	☐ Yes ☐No ☐ Yes ☐No ☐ Yes ☐No
Financial Information	☐ Cell ☐ Home ☐ Work	☐ Yes ☐No ☐ Yes ☐No ☐ Yes ☐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

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	☐Yes ☐No		
Parent 2	☐Yes ☐No		
Sibling	☐Yes ☐No		
Sibling	☐Yes ☐No		
Sibling	☐Yes ☐No		
Sibling	☐Yes ☐No		

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)**

- ☐ 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	☐0	☐1	☐2	☐3
2. Not being able to stop or control worrying	☐0	☐1	☐2	☐3
3. Worrying too much about different things	☐0	☐1	☐2	☐3
4. Trouble relaxing	☐0	☐1	☐2	☐3
5. Being so restless that it's hard to sit still	☐0	☐1	☐2	☐3
6. Becoming easily annoyed or irritable	☐0	☐1	☐2	☐3
7. Feeling afraid, as if something awful might happen	☐0	☐1	☐2	☐3
1. Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
2. Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3
3. Trouble falling or staying asleep, or sleeping too much	☐0	☐1	☐2	☐3
4. Feeling tired or having little energy	☐0	☐1	☐2	☐3
5. Poor appetite or overeating	☐0	☐1	☐2	☐3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐0	☐1	☐2	☐3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐0	☐1	☐2	☐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	☐0	☐1	☐2	☐3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐0	☐1	☐2	☐3

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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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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

SUBMIT