CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Clinic Patient Information

Please print carefully and answer all questions

Date _____

Patient legal name _____ Sex: M / F
LAST FIRST MIDDLE

_____
MAILING ADDRESS CITY ST ZIP

_____
PHYSICAL ADDRESS CITY ST ZIP

_____
HOME PHONE # CELL PHONE # SS# DATE OF BIRTH

_____
EMPLOYER ADDRESS PHONE #

Guarantor *(Please complete if different from above)*

Responsible party name _____
LAST FIRST MIDDLE

_____
ADDRESS CITY ST ZIP

_____
HOME PHONE # WORK PHONE # SS# DATE OF BIRTH

_____
EMPLOYER ADDRESS PHONE #

Insurance Information

Primary Insurance _____

_____
SUBSCRIBER (Person who carries insurance) GROUP # POLICY #

Supplemental Insurance _____

_____
SUBSCRIBER (Person who carries insurance) GROUP # POLICY #

DSHS Medical Coupons: PIC# _____

State Industrial / Self-Insured Workers' Comp _____

Injury Date _____ Claim # _____

Employer _____

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

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Adult Health History and Review of Systems

Today's Date: _____ Patient Name: _____ Date of Birth: _____

MEDICAL PROBLEMS SINCE YOUR LAST VISIT Please list any major problems or consults you have had since your last visit here, please include the name of the provider you saw.

MEDICATIONS Please list <u>all</u> medications that you take, prescription and non-prescription	
Medication	**Dose**

MEDICATION ALLERGIES List any reactions you have had to medications (for example, penicillin or sulfa) <u>Please list new allergies first.</u>

FAMILY HISTORY Please circle the problem and give the age when the problem began, if known.					
ILLNESS	**MOTHER**	**FATHER**	**SISTERS**	**BROTHERS**	**GRANDPARENTS**
Diabetes					
Breast, prostate or colon cancer					
Heart disease or heart attack					
High blood pressure					
Stroke					
Alcoholism					
Osteoporosis (weak bones, hip fracture)					
Depression / Anxiety / Bipolar					
Gall Bladder / Kidney Stones / Stomach Ulcer					
Other					

CURRENT HEALTH PRACTICES
Do you exercise regularly? **YES** **NO** If yes, what type of exercise: _____ Do you feel it is important to lose weight at this time? **YES** **NO**
Do you drink alcohol? **YES** **NO** If yes, what kinds: _____

On average, how much do you drink per day: _____ Per week: _____

Have you ever used tobacco products regularly? **YES** **NO** If yes, please answer the following:
Tobacco Product: _____ Age Started: _____ Years Used: _____ Average amount per day: _____
Are you still using: **YES** **NO** Year Quit: _____

Do you drink caffeine products? **YES** **NO** If yes, how much per day: _____

Do you use marijuana? **YES** **NO** If yes, how much and how often: _____

How often do you use your seatbelt: **ALWAYS** **SOMETIMES** **NEVER**

Check any of the following symptoms you have experienced WITHIN THE PAST 3 MONTHS

General:
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Concerned about weight
- ☐ Abnormal weight gain
- ☐ Abnormal weight loss
- ☐ Fatigue
- ☐ Weakness
- ☐ General feeling of discomfort
- ☐ Sleep disorder
- ☐ Persistent infections
- ☐ HIV exposure

Respiratory:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Breathing disturbs sleep
- ☐ Coughing up blood
- ☐ Excessive sputum
- ☐ Snoring
- ☐ Excessive snoring
- ☐ Asthma

Cardiovascular:
- ☐ Chest pain or discomfort
- ☐ Fainting
- ☐ Near fainting
- ☐ Pain in legs with exertion
- ☐ Palpitations
- ☐ Shortness of breath at night
- ☐ Shortness of breath when lying down
- ☐ Shortness of breath with exertion
- ☐ Swelling of hands or feet
- ☐ Vertigo (Dizziness)
- ☐ Weight gain
- ☐ Bluish color lips/nails

Eyes:
- ☐ Decreased vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Vision loss – 1 eye
- ☐ Eye irritation
- ☐ Blurring
- ☐ Vision loss – both eyes
- ☐ Halos
- ☐ Light sensitivity
- ☐ Eye discharge
- ☐ Eye injury
- ☐ Eye debris
- ☐ Ocular migraine

GI:
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Dark tarry stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Excessive appetite
- ☐ Loss of appetite
- ☐ Hernia

Muscle Skeletal:
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint fluid present
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Loss of muscle
- ☐ Gout
- ☐ Arthritis
- ☐ Stiffness
- ☐ Knee pain
- ☐ Shoulder pain

Ears, Nose, Throat:
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Hoarseness
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Nasal congestion

Urinary (GU):
- ☐ Discharge
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Frequent night time urination
- ☐ Frequent
- ☐ Problems/changes with stream

Dermatology:
- ☐ Rash
- ☐ Change in moles
- ☐ Suspicious lesions
- ☐ Excessive sweating
- ☐ Night sweats
- ☐ Changes in nail beds
- ☐ Dry skin

- ☐ Ear ache
- ☐ Ringing in ears
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Enlarged tonsils
- ☐ Enlarged adenoids
- ☐ Foul urinary discharge
- ☐ Inability to empty bladder
- ☐ Urinary urgency
- ☐ Unusual urine color
- ☐ Kidney pain
- ☐ Genital sores
- ☐ Lack of sexual drive
- ☐ Abnormal vaginal discharge
- ☐ Poor wound healing
- ☐ Unusual hair distribution
- ☐ Skin cancer
- ☐ Itching
- ☐ Changes in skin color
- ☐ Flushing
- ☐ Yellow skin color
- ☐ Eczema (itchy or irritated skin)

Check any of the following symptoms you have experienced WITHIN THE PAST 3 MONTHS

Neurology:

- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures
- ☐ Tremors
- ☐ Difficulty with concentration
- ☐ Poor balance
- ☐ Coordination difficulties
- ☐ Inability to speak
- ☐ Falling down
- ☐ Tingling
- ☐ Brief paralysis
- ☐ Visual disturbance

Endo:

- ☐ Cold intolerance
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Heat intolerance
- ☐ Weight change

Allergy:

- ☐ Bee sting allergy
- ☐ Food allergies
- ☐ Hives or rash

Psychology:

- ☐ Anxiety
- ☐ Depression
- ☐ Thoughts of suicide
- ☐ Eating disorder
- ☐ Sense of great danger
- ☐ Mental problems
- ☐ Thoughts of violence
- ☐ Frightening visions/sounds

Hematology:

- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Enlarged lymph nodes
- ☐ Skin discoloration
- ☐ Fevers

Breast:

- ☐ Left breast lump
- ☐ Right breast lump
- ☐ Nipple discharge
- ☐ Bloody discharge from nipple
- ☐ Breast pain
- ☐ Abnormal mammogram
- ☐ Breast enlargement
- ☐ Abnormal ultrasound

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

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