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 # WORK 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 _____

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IRS #91-0856279

NAME _____

D.O.B. _____

PHONE #: Day_____ Evening _____

PRIMARY CARE PHYSICIAN _____

General Medical Information

Describe current medical problem / reason for today's visit: _____

Present medications: _____

Allergies to medication: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child: ❑ Yes ❑ No

Last menstrual period: _____

Do you smoke: ❑ Yes ❑ No ❑ Cigarettes ❑ Pipe ❑ Cigars No. of Years _____

How much?_____ ❑ Interested in stopping

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces /beers per day?_____

Do you drink coffee: ❑ Yes ❑ No How many cups per day? _____

Are you under a lot of pressure at home or work? ❑ Yes ❑ No

Personal Medical History

Have you ever had any of the following: (Check all that apply)

❑ Chest pain / Pressure / Tightening
❑ Hypertension
❑ Heart Attack
❑ Stroke
❑ Headaches
❑ Glaucoma
❑ Allergies or Eczema
❑ Memory Loss
❑ Hemorrhoids
❑ Asthma
❑ Dizzy Spells
❑ Cancer
❑ Diabetes
❑ Arthritis
❑ Difficulty Hearing
❑ Cataracts
❑ Digestive problem
❑ Frequent Urinary Infections
❑ Kidney Disease
❑ Shortness of Breath
❑ TB / Lung Disorder
❑ Ulcers
❑ Skin Disorders
❑ Hepatitis
❑ Depression
❑ Blood in stool

Other: _____

Immunizations

(Year last received, if known)

Tetanus: _____
Typhoid: _____
Polio: _____
Influenza: _ _____
Pneumonia: _ _____
Rubella: _____
Hepatitis: _____

Family History

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Epilepsy	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Eczema / Psoriasis	❑	❑	❑	❑	❑	❑
Heart Attack / Stroke	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Hay Fever	❑	❑	❑	❑	❑	❑

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Release of Information and 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 CMC 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

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Release of Patient Information Consent Form

I (please print name) _____

Authorize (name of person or company) _____

Reason for Release: _____

Send the information to (address of person or company): _____

Please choose one:

_____ **1. I hereby authorize** Cascade Medical (CM) to provide the above-named individual or company with all medical data and information they may request concerning my illness or injury.

_____ **2. I hereby refuse** CM to provide the above-named individual or company with medical data and information concerning my illness or injury.

_____ **3. I hereby authorize CM to provide the above-named individual or company with specific elements** of my medical data and information as designated below, concerning my illness or injury.

(If you choose option 3, initial which information you authorize for release)

_____ Name, address, phone number

_____ Social Security Number

_____ Date of admission

_____ Admitting diagnosis

_____ Findings of physical examination

_____ Laboratory data

_____ Reports of diagnostics tests

_____ Reports of surgical procedure

_____ Listing of medications

_____ Listing of treatments

_____ Information from physician consults

_____ Ancillary personal notes (check all those that apply)

❑ Nursing ❑ Social Services ❑ Pharmacy
❑ Dietary ❑ Psychiatric Services

Signature of Patient:_____ Date: _____

Signature of Witness:_____ Date: _____
(original to be placed in patient's medical record)

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I 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.)

cmc-plt10ppr