

Santiam Medical Associates Patient Information

Patient Name: _____

Date: _____ Date of Birth: _____

Pharmacy of Choice: _____

Office Use Only

Updated _____

____ No Change per Pt.

____ See Changes per Pt.

What town do you live in? _____

Who else lives with you presently? _____

Are you ___ Married ___ Single ___ Divorced ___ Widowed ___ Other

Number of living children _____

Are you ___ Employed ___ Unemployed ___ Retired ___ Full time homemaker

___ Disabled Why disabled? _____

Occupation _____ Any occupational hazards? _____

Have you had the following surgeries?

Yes No Appendix removed Yes No Abdominal surgery _____

Yes No Gall bladder removed Yes No Knee surgery _____

Yes No Hysterectomy or ovaries removed Yes No Carpal tunnel _____

Yes No Heart surgery (CABG) Yes No Cataract surgery _____

Yes No C-Section Yes No Tonsils and/or adenoids _____

List any other surgeries: _____

Allergies:

Yes No Latex _____

Yes No Food _____

Yes No Medication _____

Current Medications and Dosage: (Include birth control, vitamins and natural medicines) _____

Family History of Illness: (Please circle yes or no. If yes, note which family member.)

Yes No Bleeding Disorders Yes No Asthma _____

Yes No Heart Attack Yes No Seizures _____

Yes No Serious reaction to anesthesia Yes No Breast Cancer _____

Yes No Diabetes Yes No Ovarian Cancer _____

Yes No Stroke Yes No Uterine Cancer _____

Yes No High blood pressure Yes No Prostate Cancer _____

Yes No Alzheimer's Yes No Rectal/Colon Cancer _____

Yes No Osteoporosis or hip fractures Yes No Melanoma (malignant mole) _____

Other _____

Habits: (Answer yes or no to the following questions. If yes, please explain.)

Yes No Do you smoke or chew tobacco and if so, how much per day/month/year? _____

Yes No Have you ever smoked or used tobacco and if so, when did you quit? _____

Yes No Do you drink alcohol and if so, how much per day/month/year? _____

Yes No Did you ever drink alcohol and if so, when did you quit? _____

Yes No Have you used drugs in the past? _____

Yes No Do you exercise? How often? _____

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Past Medical History:

(You must circle yes or no to every question below. Add any that are not listed if necessary)

- Yes No High blood pressure
- Yes No High cholesterol
- Yes No Heart irregularity
- Yes No Heart valve disease
- Yes No Angina/Heart pain
- Yes No Heart failure
- Yes No Heart attack
- Yes No Pacemaker
- Yes No Defibrillator
- Yes No Rheumatic fever
- Yes No Thyroid problem
- Yes No Gout
- Yes No Arthritis
- Yes No Hiatal hernia
- Yes No Stomach ulcer
- Yes No Pancreatitis
- Yes No Cancer
- Yes No Radiation therapy
- Yes No Diabetes
- Yes No Asthma
- Yes No Emphysema
- Yes No Tuberculosis
- Yes No Blood clot in legs/
phlebitis
- Yes No Blood clots in lung/
embolism
- Yes No Stroke
- Yes No Liver disease
- Yes No Hepatitis
- Yes No Cirrhosis
- Yes No Kidney disease
- Yes No Anemia
- Yes No Glaucoma
- Yes No Colon polyps
- Yes No Colitis
- Yes No Diverticular disease
- Yes No Gallstones
- Yes No Steroid therapy
- Yes No Sleep apnea
- Yes No COPD

Have you ever received:

- Yes No Childhood immunizations
- Yes No Hepatitis vaccine
- Yes No Pneumococcal
- Yes No Flu Vaccine
- Yes No Tetanus toxoid
- Yes No Shingles vaccine

Do you have a:

- Yes No Living Will
- Yes No Durable power of attorney

Review of Systems:

(Please circle yes or no if in the past 3 months you have had any of the following)

General:

- Yes No Fever
- Yes No Night sweats
- Yes No Poor appetite
- Yes No Weight loss
- Yes No Injury to _____

Neurological:

- Yes No Unusual headaches
- Yes No Seizures
- Yes No Epilepsy
- Yes No Paralysis

Eyes, Ears, Nose & Throat:

- Yes No Worsening vision
- Yes No Temporary loss of vision
- Yes No Double vision
- Yes No Hearing difficulties
- Yes No Earache/drainage
- Yes No Nose bleeds
- Yes No Hoarseness
- Yes No Sores in mouth
- Yes No Do you use CPAP?

Skin:

- Yes No Changing mole
- Yes No Non-healing sores

Breasts:

- Yes No Lump
- Yes No Bloody nipple discharge
- Yes No Breastfeeding

Blood & Lymphatic:

- Yes No Easy bruising
- Yes No Lump in neck
- Yes No Lump in armpit

Bone & Joint:

- Yes No Bone pain
- Yes No Joint swelling/pain

Genital:

- Yes No Swollen testes
- Yes No Vaginal bleeding/discharge
- Yes No Painful Intercourse
- Yes No Pregnant

Heart & Lung:

- Yes No Shortness of breath (SOB)
- Yes No SOB with exertion
- Yes No SOB at rest

- Yes No SOB suddenly at night
- Yes No Chest pain/tightness
- Yes No Racing of heart/skipping beats
- Yes No Swelling ankles
- Yes No Frequent coughing
- Yes No Coughing up phlegm
- Yes No Wheezing
- Yes No Cramping of legs
- Yes No Cramping with walking
- Yes No Cramping of legs at night

Digestive:

- Yes No Heartburn
- Yes No Regurgitation of sour fluids in throat
- Yes No Difficulty swallowing
- Yes No Excessive belching
- Yes No Nausea
- Yes No Vomiting
- Yes No Gassiness in belly
- Yes No Bloating of belly
- Yes No Excessive flatus (gas)
- Yes No Pain in belly
- Yes No Antacid use
- Yes No Blood in stool (black or red)
- Yes No Constipation
- Yes No Laxative use
- Yes No Diarrhea
- Yes No Anal/Rectal pain
- Yes No Jaundice (yellow eyes)

Urinary:

- Yes No Pain/burning when urinating
- Yes No Weak stream
- Yes No Urinating at night 3 times or more

Psychiatric:

- Yes No History of depression
- Yes No History of anxiety
- Yes No History of Bipolar disorder

Health Screenings:

(If yes, give date of most recent.)

- Yes No Colonoscopy _____
- Yes No Mammogram _____
- Yes No Bone scan (Dexa scan) _____

Last physical _____

Last PSA (males) _____

Last PAP smear (females) _____

Santiam Medical Associates

PATIENT REGISTRATION FORM

Patient Information		
Name (First, MI, Last)	Date of Birth	Marital Status
Mailing Address	Sex	Home Phone
City, State, Zip	Relation to Guarantor	Work Phone
Patient's Employer (or School)	Position (or Student)	Social Security Number
Address (Street, City, State, Zip)		

Guarantor/Responsible Party		
Name (First, MI, Last)	Sex	Date of Birth
Mailing Address	Home Phone	Social Security Number
City, State, Zip	Work Phone	Marital Status
Patient's Employer (or School)	Position	
Address of Employer (Street, City, State, Zip)		
Name of Spouse		

Insurance Information		
Name of person carrying information (First, MI, Last)	Date of Birth	Insurance ID Number or SSAN
Address of person carrying insurance (if different than guarantor)		
Name of Insurance Company	Name of Group/Plan	Group Number
Address of Insurance Company (Street, City, State, Zip)		Relationship to Patient

Other Information
Name of Previous Physician
In Case of Emergency Notify (Name, Telephone)

I authorize the release of any medical records necessary to properly process my insurance claim. I understand that I am directly responsible for any charges in this account and, if applicable, I authorize my insurance company to send payment directly to the doctor providing treatment.

SIGNED

DATE

Financial Policy

Our desire is to serve you and to provide quality, professional, courteous care for you and your family's medical needs. The following items are to assist you in knowing your financial responsibilities prior to treatment. Please remember that your insurance coverage is a contract between you and/or your employer and the insurance company. We will bill your insurance as a courtesy to you, but you, the patient or responsible party, are the one who is ultimately responsible for payment.

1. Co-payments, for insurance companies that require them, are the responsibility of the patient and are due at the time of service. An additional billing fee of \$5.00 will be incurred if a statement must be sent for an unpaid co-payment.
2. After submitting a claim to the insurance company we will await payment for a maximum of 60 days. If no payment is received in the 60-day period, the patient agrees to pay the balance in full. We will be happy to refund any credit balance if the insurance company subsequently pays us.
3. After receiving payments from the insurance company, any balance owing will come to the patient on a remainder statement. We do not send out statements unless a balance is due from the patient or responsible party.
4. Any balance past due over 90 days from the date of the first statement will be assessed a billing charge of \$5.00 for each additional month it remains unpaid unless a payment plan has been agreed upon and regular payments are being made.
5. New patients – If you do not have insurance or you do not have your card with you, payment will be required at the time of service. This may be by cash or check. We do accept credit and debit cards.
6. Medicaid and Oregon Health Plan participants must present a valid, current medical card. If the card is not presented, the patient may sign a waiver and pay cash for the visit or we will assist them in rescheduling their appointment for another time so that they may bring their card with them. This rescheduling will be waived only if the visit is an emergency. If the Medicaid or Oregon Health Plan participant signs a waiver, pays cash, and then later brings in their medical card, we will bill their plan and refund any credit balance when the insurance pays.
7. A \$25.00 fee will be assessed for each returned check. Cash or money order must be presented to cover the returned check plus the \$25.00 returned check fee before the patient will be seen again in the office.
8. Out of state Medicaid insurances will not be billed or accepted. Cash payments for services will be expected.

I hereby certify that I have read and agree to the terms of this financial policy. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of patient or responsible party

Date