|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Family Medical Clinic of Chubbuck  **PLEASE COMPLETE ALL SECTIONS** | | | | | | | | | |
| Last Name: First Name: M.I.: Preferred Name: | | | | | | | Previous Name: (if applicable) | | |
| Mailing Address: | | | | | City/State/Zip: | | | | |
| Home Phone: | | | Cell Phone: | | | | | Social Security #: | |
| Marital Status: | Date of Birth: | | | Sex: Male □ Female □ | | | **Is today’s visit for an Auto Accident or Workers Compensation?** | | |
| Email address: | | | | | May we leave a voice mail regarding your medical care, test results, & billing?  Yes □ No □ | | | | |
| Primary Physician: | | | | | Other Physicians Caring for You/Physician who Referred You: | | | | |
| Employer Name: Phone: | | | | | Employer Complete Address: | | | | |
| Emergency Contact: | | | Phone: | | | | | Relationship to Patient: | |
| Name of Spouse or Significant Other: | | | | | | Employer of Spouse or Significant Other: | | | |
| Date of Birth: | | | Social Security #: | | | | | Phone: | |
| Address of Spouse or Significant Other: | | | | | City/State/Zip: | | | | |
|  | | | | |  | | | | |
| Name of Guarantor/Person/Parent responsible for payment of services (Only if different than insured): | | | | | | | | | |
| Date of Birth: | | | Social Security #: | | | | | Phone: | |
| Address of Person Responsible: | | | | | City/State/Zip: | | | | |
| Employer of Person Responsible: | | | | | Relationship to Patient: | | | | |
| **Primary Medical Insurance** | | | | | **Secondary Medical Insurance** | | | | |
| Ins. Co. Name: | | | | | Ins. Co. Name: | | | | |
| **Policy Holder Name:** | | | | | **Policy Holder Name:** | | | | |
| Subscriber ID Number: Group #: | | | | | Subscriber ID Number: Group #: | | | | |
| **Policy Holder's Date of Birth: Policy Holder's Address:** | | | | | **Policy Holder's Date of Birth: Policy Holder's Address:** | | | | |
| Policy Holder's Social Security #: | | | | | Policy Holder's Social Security #: | | | | |
| Patient Relationship to Policy Holder: | | | | | Patient Relationship to Policy Holder: | | | | |
| **Employer Name:** | | | | | **Employer Name:** | | | | |
| Ethnicity (please select one): | | Hispanic or Latino □ | | | Not Hispanic or Latino □ | | | | Decline □ |
| English □ | | Spanish □ | | | Sign Language □ | | | | Other |
| **Preferred Pharmacy Name, Location & Phone:** | | | | | | | | | |
| **No Show/Late Cancellation Policy:** Kindly give us 24-hour notice if you need to change your appointment. Any appointment cancelled on the same day or less than 24 hours may count as a no show. I understand that if I no show or late cancel three (3) times I may not be scheduled for future appointments. If you have any questions, please ask our staff.  **Acknowledgement of Notice of Privacy Practices:** I have been presented with a copy of the Notice of Privacy Practices for FMCC, detailing how my information may be used and disclosed as permitted under federal and state law.  **Signature of Responsible Party:**  **Date:** | | | | | | | | | |
|  | | | | | | | | | |
|  | | |  | | | | |  | |

**Payment Policy & Signatures**

**Signature on File:** I hereby authorize FAMILY MEDICAL CLINIC OF CHUBBUCK, hereafter known as FMCC, to furnish insured’s health insurance company, or representatives thereof, all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested regarding my physical condition, injury and treatment rendered. I also authorize the release of information regarding work-related injuries to my employer. I understand that I am financially responsible for all charges incurred on my behalf. If required, this authorization meets the Medicare Signature on File Requirement.

I UNDERSTAND THAT THIS REMAINS IN EFFECT UNTIL REVOKED IN WRITING. ***Initials \_\_\_\_\_\_\_\_\_\_\_***

**Assignment of Insurance Benefits:**

|  |
| --- |
| I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to FMCC all monies to which I am entitled for medical expenses related to the services performed from time to time by FMCC, but not to exceed my indebtedness to FMCC. Any monies received from such insurance company over and above such indebtedness will be refunded to me when my bill is paid in full. I hereby authorize payment directly to FMCC of all medical insurance benefits including Major Medical payments otherwise payable to me. **I understand that I am financially responsible for all charges including any labs, tests or procedures not covered under my insurance plan or plans and/or excess of the benefits paid under such plan or plans. I also understand and agree to complete a COORDINATION OF BENEFITS (COB) with any past and present insurance companies, if I do not complete this I understand I will be responsible for payment of services provided at FMCC.** A photographic copy of this authorization shall be valid as the original.  I UNDERSTAND THAT THIS REMAINS IN EFFECT UNTIL REVOKED IN WRITING. ***Initials \_\_\_\_\_\_\_\_\_\_\_*** |
|  |

**Payment Policy:** Co-Insurance amounts, Co-Payment amounts and/or deductibles are due at the time of service. Patients are responsible for all charges that are not covered by insurance or not paid in full by insurance. Payments are due on all accounts at FMCC every 30 days. I understand and agree that in the event of non-payment of any amount due more than 90 days, FMCC may add interest at the rate of 1.75% per month (21% annum). I further understand and agree that in the event any unpaid balance is assigned to a third party for collection an additional collection fee of 35% of the unpaid balance will be added.

Note: Medicare patients will *not* be charged collection or finance fees.

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to FMCC. I authorize any holder of medical information about me to release to Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I will be charged a $20.00 inconvenience fee for any payment that does not process through the bank. ***Initials\_\_\_\_\_\_\_\_\_\_***

I have read and agree to the above Family Medical Clinic of Chubbuck’s (FMCC) payment policy.

Patient Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a minor or you have POWER OF ATTORNEY for this patient, please complete the following as it applies to all of the above and provide a copy of POWER OF ATTORNEY documentation.

Patient Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Updated 2/2024**

MEDICAL HISTORY FORM

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL HISTORY Recreational Drug Use: Current / Past / Never Last date used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking or Vaping: Current / Past / Never Number per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: Current / Past / Never Drinks per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List ALL YOUR MEDICATIONS dosage and times taken. If you don’t know, please call your pharmacy to confirm.

Medications/Dosage/Frequency OTC and Vitamins/Dosage/Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **My** **pharmacy is:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List other medical providers you see on a regular basis and any changes to you medical history.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHQ2: Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things:

Not at all          Several days          More than half the days          Nearly every day

2. Feeling down, depressed or hopeless:

Not at all          Several days          More than half the days          Nearly every day

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Disease or Condition*** Check all that apply | Self | Father | Mother | Siblings |
| ADHD |  |  |  |  |
| Alcoholism |  |  |  |  |
| Allergies |  |  |  |  |
| Anemia or Bleeding tendencies or nosebleeds (circle applicable) |  |  |  |  |
| Anxiety or Depression (circle one or both) |  |  |  |  |
| A-fib/Arrhythmia (irregular heartbeat) |  |  |  |  |
| Arthritis (circle type) Rheumatoid, Osteo, Psoriatic, other |  |  |  |  |
| Asthma |  |  |  |  |
| Bladder problems or Incontinence (circle applicable) |  |  |  |  |
| Cancer(s) (Indicate type for appropriate person) |  |  |  |  |
| Carpal tunnel |  |  |  |  |
| Chronic pain (Indicate type for appropriate person) |  |  |  |  |
| Dementia |  |  |  |  |
| Diabetes: Type 1 or 2 (circle type) |  |  |  |  |
| Diverticulitis |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Disease or Condition*** Check all that apply | Self | Father | Mother | Siblings |
| DVT’s (blood clots) |  |  |  |  |
| Eczema |  |  |  |  |
| Emphysema |  |  |  |  |
| Gallstones |  |  |  |  |
| GERD (Acid Reflux) |  |  |  |  |
| Glaucoma |  |  |  |  |
| Headaches or Migraines (circle one or both) |  |  |  |  |
| Heart Attack or heart disease (circle one or both) |  |  |  |  |
| Hepatitis |  |  |  |  |
| Hiatal Hernia |  |  |  |  |
| High Blood Pressure (HTN) |  |  |  |  |
| High Cholesterol (Hypercholesterolemia) |  |  |  |  |
| HIV |  |  |  |  |
| Irritable Bowel Syndrome (IBS) |  |  |  |  |
| Kidney Disease or Stones (circle one or both) |  |  |  |  |
| Liver Disease |  |  |  |  |
| Lupus |  |  |  |  |
| Macular Degeneration |  |  |  |  |
| Mental Health Conditions |  |  |  |  |
| Neuropathy |  |  |  |  |
| Osteopenia or Osteoporosis (circle one or both) |  |  |  |  |
| Parkinson’s Disease |  |  |  |  |
| PE (Pulmonary Embolism/blood clot in lungs) |  |  |  |  |
| Sciatica |  |  |  |  |
| Seizure Disorder |  |  |  |  |
| Sleep Apnea |  |  |  |  |
| Stroke |  |  |  |  |
| Thyroid Disorder |  |  |  |  |
| Ulcerative Colitis |  |  |  |  |
| PLEASE LIST ANY OTHERS |  |  |  |  |

List Surgeries & Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Month/year of last: Colonoscopy Pap Smear Mammogram Flu vaccine\_\_\_\_\_\_\_\_\_ RSV vaccine

Pneumonia vaccine Shingles vaccine\_\_\_\_\_\_\_\_\_\_COVID vaccine COVID booster

Females: Number of pregnancies\_\_\_\_\_\_Number of live births\_\_\_\_\_\_Age of first period\_\_\_\_\_\_Age of Menopause\_\_\_\_\_\_

Please list cause & age at death: Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***There HAVE BEEN NO changes to my medical history within the last year. INITIAL HERE\_\_\_\_\_\_\_\_\_\_\_\_& SIGN BELOW***

**Patient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

**Medical Staff reviewed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date \_\_\_\_\_\_\_\_\_\_\_

476 E. Chubbuck Rd. Chubbuck Idaho 83202

(208) 233.9898 Phone (208) 232.8566 Fax

**Permission to Discuss Medical Information**

All medical records are protected health information. We require written authorization to release medical information to anyone other than the patient. By signing the authorization below, you are giving us permission to discuss the information contained in your medical chart with another individual.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (YOUR LEGAL NAME), give the providers and staff of *Family Medical Clinic of Chubbuck* permission to discuss my diagnosis, procedures, medications, and/or treatment plan with those listed below.

This document is *valid for one year from the date below unless otherwise specified*.

Name: (please print clearly) Relationship: Phone: Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient LEGAL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: (*not valid unless signed)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FMCC Staff Signature & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (YOUR LEGAL NAME), **DO NOT** wish to grant permission to anyone at this time.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FMCC Staff Signature & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_