



Cascade West  
PRIMARY CARE CLINIC

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[www.cascadewestprimarycare.com](http://www.cascadewestprimarycare.com)

Dear Patient,

Thank you for choosing our practice for your medical needs! Enclosed are patient information forms for you to fill out, including a medical problem list, past medical history, surgical history, family history, and social history.

Fill out all forms to the best of your knowledge, and if you need any assistance with these forms, we are here to help you.

Please bring in your medication bottles and all medications for your office visits if needed or if requested to.

You will be required to present your insurance card with each office visit, and we do bill your insurance unless you elect to self-pay with cash, card, or check.

Thank you, we look forward to meeting you! Be sure to also visit us at our website to learn more about our practice!

## THINGS TO REMEMBER

**We are primary care providers**, and as such we can provide your health care needs with physical examinations, mental health management, medications, labs, imaging, referrals, and more depending on the case.

**Scheduling:** Please call the receptionist for all scheduling at 541-787-4360 or leave a message. Remember to be courteous to other patients. If you cannot keep your appointment, please call at least 24 to 48 hours in advance to cancel or reschedule an appointment.

**If you have an injury on the job or a motor vehicle accident**, please seek immediate attention at the ER or Occupational Health.

### **Office Hours:**

- Monday, Tuesday, and Thursday from 8:30 am to 12:00 pm and 2:00 pm to 5:00 pm. Wednesdays and Fridays by appointment only.
- Our phones are off between 12:00 pm and 2:00 pm, but you may leave messages.
- Wednesdays on specified dates for diabetes, COPD, and educational classes.
- Same day and urgent care appointments are available.

**After Hours:** If you are an established patient, you can reach the “on-call” health care provider by calling our on-call number at 541-787-7591. The on-call number is to be used for urgent needs. If you have an emergency **ALWAYS CALL 911**.

The on-call number is **NOT:**

- To be called during office hours
- For medication refills
- For appointments

**ER Visits:** If at any time you need emergency medical care, call 911 to be evaluated. The emergency room physician will evaluate you and determine if you need to be admitted. You will be assigned a physician for your hospital stay **ONLY**, and this physician can obtain needed medical records and any health information from your primary care provider to assist in your care and will advise us of your health status.

If we need to admit you directly to the hospital, we can pre-arrange this with one of our hospitalist physicians who will follow you throughout your stay at the hospital.

However, we can follow you in the nursing or rehabilitation units and arrange for all your health care needs.

**Medications:**

- **Our office does not traditionally provide chronic opioid pain management. Our staff is, however, able to assist you in establishing with a pain management specialist.**
- When calling for medication refills, please allow 5 to 7 days for processing.

**Our policies:**

- You will be required to present your insurance card with each office visit.
- Please call at least 24 to 48 hours in advance to cancel or reschedule an appointment.
- Missed appointments may result in a \$55 charge and may be increased for each additional missed appointment, except in an emergency.
- Three “No Show” or missed appointments may result in termination of services.
- Co-pays and cash pay visits are due at the time of service.
- There may be a \$25 charge for completion of extensive forms. This is due prior to completion of forms.
- **We do not sign off or fill out paperwork for medical marijuana, disability, motor vehicle accidents, or worker’s compensation.**

For the comfort of our staff and other patients, please do not smoke just prior to your visit or wear heavy perfumes or scented lotions. For exams, please shower.

If you are having respiratory symptoms, a cold, or are running a fever, we ask that you wear a mask in the waiting room and during your exam to protect others as well as staff.

**By signing below, I have read and understood the information above.**

---

Signature of patient

Date

## PATIENT INFORMATION

Full name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Street address: \_\_\_\_\_ Message phone: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Gender:  Male  Female  Transgender: \_\_\_\_\_

Single  Married  Partner  Widowed  Divorced  Separated

Employer/Company: \_\_\_\_\_

Business address: \_\_\_\_\_

Responsible Party if other than the above: \_\_\_\_\_

Relationship to Patient:  Spouse  Parent  Relative  Guardian

Street address: \_\_\_\_\_ Message phone: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Employer/Company: \_\_\_\_\_

Business address: \_\_\_\_\_

Do you have health insurance?  Yes  No

Name of insurance carrier: \_\_\_\_\_

Group name or number: \_\_\_\_\_

Medicare number: \_\_\_\_\_ Medicaid number: \_\_\_\_\_

Person to notify in Case of Emergency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

The health care providers at Cascade West Primary Care Clinic participate in the Medicare Assignment Program and may legally charge you the Medicare determined annual deductible and per visit co-payments.

**I hereby authorize Cascade West Primary Care Clinic to furnish my insurance company all information which the insurance company may request concerning my present illness or injury.**

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

## ACKNOWLEDGEMENT AND CONSENT

I understand that the health care providers at Cascade West Primary Care Clinic (referred to below as "This Practice" will use and disclose health information about me.

I understand my health information may include information both created and received by the practice, may be in the form of written or electronic record or spoken words, and may include information about my health history, health status, symptoms, examination, test results, diagnosis, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all my health care.
- Perform various office, administrative, and business functions that support my practitioner's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practice may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that law does not require This Practice to agree with such requests.

Signature of patient	Date

OR

Signature of patient representative	Date
Description of representative's authority: _____	

## HIPAA

To comply with the Health Insurance Portability and Accountability Act (HIPAA) which protects patient health information, our office requires written permission to send correspondences to you through the mail, to leave voice mail messages at your office or work, and if necessary to send you information via fax. Please initial each of the following to indicate your permission for each type of correspondence.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Postal mail: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Answering machine at home: \_\_\_\_\_

Answering machine at work: \_\_\_\_\_

### AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby give my permission to the health care providers of Cascade West Primary Care Clinic and their office staff to discuss my medical information, when necessary, with the following list of people. **We will not be able to share ANY of your information with anyone that is NOT on this form!**

Name	Relationship	Phone

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

## **PRIOR AUTHORIZATIONS & REFERRALS POLICY**

Many insurance companies now require a “prior authorization” for your health care provider to prescribe a medication or order diagnostic tests. Basically, what this means is that paperwork, phone calls and a lot of additional time are now required to get these medications and diagnostic tests approved by your insurance. Thus, the workload of your health care provider and office staff is drastically increased.

Related to the increased amount of work and time due to the requirements listed above, our office has been forced to adopt policies to manage this problem.

### **Prior Authorizations for Medications**

- All prior authorization requests may take anywhere from 1 to 2 weeks from the time the request is received in our office.

### **Prior Authorizations for Diagnostic Tests**

- All prior authorization requests for diagnostic tests may take up to 1 to 3 weeks, depending on your insurance company’s policies.
- If the diagnostic testing is urgently needed or considered emergent, the process is completed promptly.

### **Referrals**

- Referrals to other health care providers may take up to 1 to 2 weeks unless it is an urgent referral.

### **Forms**

- For the completion of extensive forms there may be a \$25 charge. This charge is due prior to the completion of the process.

**By signing below, I have read and understand the information above.**

---

Signature of patient

Date

**Patient name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Explain your chief reason for today's appointment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What active health disorders do you have? **Specify disorders in blanks provided if necessary.**

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Cancer, type:
<input type="checkbox"/> History of heart attack, date: _____	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Chronic acid reflux	<input type="checkbox"/> Chronic sciatica
<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Carpal tunnel syndrome
<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Seizure disorder (epilepsy)
<input type="checkbox"/> Hepatitis, type:	<input type="checkbox"/> History of stroke, date:
<input type="checkbox"/> Hernia, type: _____	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Depression
<input type="checkbox"/> Type 1 diabetes	<input type="checkbox"/> Mental illness:
<input type="checkbox"/> Type 2 diabetes	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Chemical addiction:
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low testosterone	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Obesity	<input type="checkbox"/> COPD
<input type="checkbox"/> Dental disorder: _____	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Visual disorder:	<input type="checkbox"/> Skin disorder:
<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney disorder: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Recurrent urinary infections
<input type="checkbox"/> Other health disorders: _____	

Do you have any environmental, food, or medication allergies?      **Yes**    **No**

<u>Allergen</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____





Please list all major surgical procedures you have had during your lifetime. If you have not had any surgical procedures, please specify:

<u>Type of operation</u>	<u>Location/hospital</u>	<u>Year</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been advised to have a surgery which was not performed?

**Yes No** If yes, please state reason:

\_\_\_\_\_

\_\_\_\_\_

Please list any family health issues you are aware of by using the list below.

<b><u>Living (list age)</u></b>	<b><u>Health problems</u></b>	<b><u>If deceased, list cause and age at death</u></b>
Mother: _____	_____	_____
	_____	
Father: _____	_____	_____
	_____	
Brothers: _____	_____	_____
_____	_____	_____
_____	_____	_____
Sisters: _____	_____	_____
_____	_____	_____
_____	_____	_____
Maternal grandmother:	_____	_____
Paternal grandmother:	_____	_____
_____	_____	_____
Maternal grandfather:	_____	_____
Paternal grandfather:	_____	_____
_____	_____	_____
Aunts: _____	_____	_____
_____	_____	_____
Uncles: _____	_____	_____
_____	_____	_____
_____	_____	_____

When did you last have lab work done? \_\_\_\_\_

When was your last colonoscopy? \_\_\_\_\_

Last flu shot? \_\_\_\_\_

Last pneumonia shot? \_\_\_\_\_

Last shingles shot? \_\_\_\_\_

Last tetanus shot? \_\_\_\_\_

Do you have any previous or current health care providers? Please specify:

\_\_\_\_\_

Have you previously seen or are currently seeing a cardiologist? Please specify:

\_\_\_\_\_

Have you previously seen or are currently seeing a pain management specialist?  
Please specify:

\_\_\_\_\_

Have you previously seen or are currently seeing mental health counseling? Please specify:

\_\_\_\_\_

Are you seeing any other types of health care (cancer specialist, dermatology, eye specialist, kidney specialist, urology, etc.)? Please specify:

\_\_\_\_\_

Are you now or have in the past received medical care at the VA? \_\_\_\_\_

### Females Only

Last GYN exam: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Last Pap smear: \_\_\_\_\_

Live births: \_\_\_\_\_

Last mammogram: \_\_\_\_\_

Abortions: \_\_\_\_\_

Last bone density: \_\_\_\_\_

Miscarriages: \_\_\_\_\_

How old were you when you started your periods? \_\_\_\_\_

At what age did you enter menopause? \_\_\_\_\_

How many days do you flow? \_\_\_\_\_ How many days apart are your periods? \_\_\_\_\_

Is your menstrual flow? **light** **average** **heavy**

Have you had any problems with **(circle all that apply)**?

Endometriosis

Ovarian cysts

History of abnormal Pap smear

Uterine fibroids

### Males Only

Last GU exam: \_\_\_\_\_

Have you had any problems with **(circle all**

Last prostate exam: \_\_\_\_\_

**that apply)**?

Last PSA: \_\_\_\_\_

Prostatitis

Please give us a summary of your social history by **circling the correct answers and filling in blanks where necessary**.

What is your current or past occupation, or are you retired or on disability? If you do work, how many hours per week?

**Yes No** Have you ever been exposed to any occupational hazards such as toxic metals, fumes, dust, chemicals, paint, radioactive material, etc.? If yes, please explain: \_\_\_\_\_

**Yes No** Recent past or foreign travels (especially in the tropics)? If yes, place of travel and year: \_\_\_\_\_

**Yes No** Do you do any heavy lifting, and if so, how many pounds? \_\_\_\_\_

**Yes No** Do you exercise regularly? If yes, what type, how many times per week, and for what duration? \_\_\_\_\_

**Yes No** Do you eat three well-balanced meals daily?

How many hours do you sleep at night? \_\_\_\_\_

**Yes No** Do you wear glasses or contacts? If yes, which or both? \_\_\_\_\_

**Yes No** Do you wear dentures? If yes, upper, lower, or both? \_\_\_\_\_

**Yes No** Do you wear hearing aids? If yes, left, right, or both ears? \_\_\_\_\_

**Yes No** Do you use portable oxygen (O<sub>2</sub>)? If yes, specify settings and how often used: \_\_\_\_\_

**Yes No** Do you use a cane, walker, or manual or powered wheelchair? If yes, specify: \_\_\_\_\_

**Yes No** Do you wear a prosthesis? If yes, specify: \_\_\_\_\_

**Yes No** Do you have a Living Will or Advanced Directives? If yes, specify: \_\_\_\_\_

**Yes No** Are you an organ donor?

**Yes No** Do you drink alcohol? If yes, type and amount per week, per day, per month, per year, etc.:

Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_

**Yes No** Do you drink caffeine? If yes, type and amount per day: \_\_\_\_\_

**Yes No** Do you smoke? If yes, age you started \_\_\_\_\_ packs per day \_\_\_\_\_

If you quit, date you quit \_\_\_\_\_ and for how many years did you smoke? \_\_\_\_\_

**Yes No** Do you chew tobacco or smoke cigars or a pipe? If yes, specify type and how often used: \_\_\_\_\_

**Yes No** Do you use recreational drugs? If yes, specify type and how often used: \_\_\_\_\_

Right now, do you have any of the following symptoms? Please check only if the symptom is frequent and has caused a definite impairment in your state of well-being.

**Constitutional**

<input type="checkbox"/> Body aches	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Chills	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Fever	<input type="checkbox"/> Weight loss

**Breast**

<input type="checkbox"/> Abnormal changes in size or contour	<input type="checkbox"/> Swelling
<input type="checkbox"/> Lumps	<input type="checkbox"/> Tenderness
<input type="checkbox"/> Nipple discharge	

**Cardiovascular**

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rapid heart rate
<input type="checkbox"/> Irregular heartbeat	

**Gastrointestinal**

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Excessive belching
<input type="checkbox"/> Black, tar-like stools	<input type="checkbox"/> Excessive flatulence
<input type="checkbox"/> Bloating	<input type="checkbox"/> Fecal incontinence
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Blood in vomit	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Constipation	<input type="checkbox"/> Narrow stools
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Vomiting

**Head, Ear, Nose, and Throat**

<input type="checkbox"/> Dental pain	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Dry lips	<input type="checkbox"/> Neck stiffness
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Ear fullness	<input type="checkbox"/> Postnasal drip
<input type="checkbox"/> Gum bleeding	<input type="checkbox"/> Recent head injury
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sinus pain
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Snoring
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Thyroid mass
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Nasal discharge	<input type="checkbox"/> Vertigo

**Eyes**

<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Changes in vision	<input type="checkbox"/> Floaters
<input type="checkbox"/> Discharge from the eyes	<input type="checkbox"/> Foreign body sensation
<input type="checkbox"/> Double vision	<input type="checkbox"/> Impaired vision
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Peripheral vision changes
<input type="checkbox"/> Eye discomfort	<input type="checkbox"/> Poor night vision

**Genitourinary**

<input type="checkbox"/> Change in urine color	<input type="checkbox"/> Scrotal mass
<input type="checkbox"/> Decreased urine stream	<input type="checkbox"/> Scrotal pain
<input type="checkbox"/> Genital sores	<input type="checkbox"/> Urinary difficulty
<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Urinary dribbling
<input type="checkbox"/> Impotence	<input type="checkbox"/> Urinary frequency
<input type="checkbox"/> Irregular periods or spotting	<input type="checkbox"/> Urinary hesitancy
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Penile discharge	<input type="checkbox"/> Urinary urgency
<input type="checkbox"/> Penile lesions	<input type="checkbox"/> Urination at night
<input type="checkbox"/> Possible pregnancy	<input type="checkbox"/> Vaginal discharge

**Musculoskeletal**

<input type="checkbox"/> Back pain	<input type="checkbox"/> Limitation of motion
<input type="checkbox"/> Hip pain	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Joint pain	<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Knee pain	<input type="checkbox"/> Shoulder pain

**Neurologic**

<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Seizures
<input type="checkbox"/> Memory difficulties	<input type="checkbox"/> Speech difficulties
<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Tremors

**Psychiatry**

<input type="checkbox"/> Alcohol addiction	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Anger	<input type="checkbox"/> Physical abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Prescription drug addiction
<input type="checkbox"/> Bipolar/manic-depressive disorder	<input type="checkbox"/> PTSD
<input type="checkbox"/> Depression	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Domestic abuse	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Emotional abuse	<input type="checkbox"/> Street drug addiction
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Suicidal thoughts or attempts
<input type="checkbox"/> Marijuana addiction	<input type="checkbox"/> Tobacco addiction

**Respiratory**

<input type="checkbox"/> Abnormal sputum	<input type="checkbox"/> Productive cough
<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Dry cough	

**Skin**

<input type="checkbox"/> Acne	<input type="checkbox"/> Itching
<input type="checkbox"/> Changes in existing skin lesions/moles	<input type="checkbox"/> New lesions
<input type="checkbox"/> Excessive hair	<input type="checkbox"/> Pigmentation changes
<input type="checkbox"/> Fingernail/toenail changes	<input type="checkbox"/> Rash
<input type="checkbox"/> Hair growth changes	<input type="checkbox"/> Skin dryness

Other: \_\_\_\_\_

**A SMALL SURVEY TO HELP US**

How did you find out about us? Please specify:

Newspaper \_\_\_\_\_ Radio \_\_\_\_\_

Phonebook \_\_\_\_\_ Family member \_\_\_\_\_

Internet \_\_\_\_\_ Friend \_\_\_\_\_

Referred by physician or medical practice \_\_\_\_\_

Other \_\_\_\_\_

Thank you for your help!