Cascade West
PRIMARY CARE CLINIC

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Internal Medicine

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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, Thursday, Friday from 8:30 am to 12:00 pm and 2:00 pm to 5:00 pm. Wednesdays 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.**

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

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

Allergen	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Birth and childhood illnesses

☐ Chicken pox	☐ Mumps
☐ Measles	☐ Diphtheria
☐ Rheumatic fever	☐ Whooping cough

Adult illnesses (specify disorders in blanks where necessary)

☐ Dysentery	☐ Blood clot, location: _____
☐ Encephalitis	☐ Blood transfusion, date: _____
☐ Gonorrhea	☐ Nervous breakdown
☐ Malaria	☐ Influenza
☐ Meningitis	☐ Pneumonia
☐ Osteomyelitis	☐ Pleurisy
☐ Polio	☐ Tuberculosis
☐ Syphilis	

Please list any injuries (broken bones, concussions, trauma, accidents, etc.) and dates they occurred.

_____
_____
_____
_____
_____

Please list your preferred pharmacy with address: _____

Please list all the current medications that you take on a regular basis. Be sure to include **ALL** over the counter medications, vitamins, herbal supplements, eye, ear, or nose drops/sprays, etc.

Medication	**Dosage**	**How Often?**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Type of operation	**Location/hospital**	**Year**

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.

Living (list age)	**Health problems**	**If deceased, list cause and age at death**
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: _____
Last Pap smear: _____
Last mammogram: _____
Last bone density: _____

Number of pregnancies: _____
Live births: _____
Abortions: _____
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
History of abnormal Pap smear
Ovarian cysts
Uterine fibroids

Males Only

Last GU exam: _____
Last prostate exam: _____
Last PSA: _____

Have you had any problems with **(circle all that apply)**?
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 (O2)? 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

☐ Body aches	☐ Loss of appetite
☐ Chills	☐ Night sweats
☐ Fatigue	☐ Weight gain
☐ Fever	☐ Weight loss

Breast

☐ Abnormal changes in size or contour	☐ Swelling
☐ Lumps	☐ Tenderness
☐ Nipple discharge	

Cardiovascular

☐ Chest pain	☐ Rapid heart rate
☐ Irregular heartbeat	

Gastrointestinal

☐ Abdominal pain	☐ Excessive belching
☐ Black, tar-like stools	☐ Excessive flatulence
☐ Bloating	☐ Fecal incontinence
☐ Blood in stool	☐ Heartburn
☐ Blood in vomit	☐ Jaundice
☐ Constipation	☐ Narrow stools
☐ Diarrhea	☐ Nausea
☐ Difficulty swallowing	☐ Vomiting

Head, Ear, Nose, and Throat

☐ Dental pain	☐ Neck pain
☐ Dry lips	☐ Neck stiffness
☐ Dry mouth	☐ Nosebleeds
☐ Ear fullness	☐ Postnasal drip
☐ Gum bleeding	☐ Recent head injury
☐ Headaches	☐ Sinus pain
☐ Hearing loss	☐ Snoring
☐ Hoarseness	☐ Sore throat
☐ Lightheadedness	☐ Thyroid mass
☐ Nasal congestion	☐ Tinnitus
☐ Nasal discharge	☐ Vertigo

Eyes

☐ Blurred vision	☐ Eye pain
☐ Changes in vision	☐ Floaters
☐ Discharge from the eyes	☐ Foreign body sensation
☐ Double vision	☐ Impaired vision
☐ Dry eyes	☐ Peripheral vision changes
☐ Eye discomfort	☐ Poor night vision

Genitourinary

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

Musculoskeletal

☐ Back pain	☐ Limitation of motion
☐ Hip pain	☐ Muscle cramps
☐ Joint pain	☐ Muscle pain
☐ Joint swelling	☐ Muscle weakness
☐ Knee pain	☐ Shoulder pain

Neurologic

☐ Difficulty concentrating	☐ Poor coordination
☐ Loss of balance	☐ Seizures
☐ Memory difficulties	☐ Speech difficulties
☐ Numbness or tingling	☐ Tremors

Psychiatry

☐ Alcohol addiction	☐ Panic attacks
☐ Anger	☐ Physical abuse
☐ Anxiety	☐ Prescription drug addiction
☐ Bipolar/manic-depressive disorder	☐ PTSD
☐ Depression	☐ Schizophrenia
☐ Domestic abuse	☐ Sexual abuse
☐ Emotional abuse	☐ Street drug addiction
☐ Hallucinations	☐ Suicidal thoughts or attempts
☐ Marijuana addiction	☐ Tobacco addiction

Respiratory

☐ Abnormal sputum	☐ Productive cough
☐ Cough	☐ Shortness of breath
☐ Coughing up blood	☐ Wheezing
☐ Dry cough	

Skin

☐ Acne	☐ Itching
☐ Changes in existing skin lesions/moles	☐ New lesions
☐ Excessive hair	☐ Pigmentation changes
☐ Fingernail/toenail changes	☐ Rash
☐ Hair growth changes	☐ 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!