JAMESTOWN FAMILY HEALTH CLINIC

808 North 5th Ave, Sequim, WA 98382
(360) 683-5900

Thank you for your interest in becoming a patient at Jamestown Family Health Clinic. As you may know there is a shortage of Primary Medical Care Providers in our community. At Jamestown Family Health Clinic, we continue to recruit new providers to this area and create access to health care for new patients.

How to become a patient at Jamestown Family Health Clinic

Complete & return this packet to the clinic, along with copies of your

- Current Insurance card(s)
- Photo ID (State or Passport)

Schedule your New Patient Appointment

New patient appointments are scheduled on a first come, first served basis with the next available provider

Register for MyChart*

- This is the Clinic preferred method of communication
- You will receive your MyChart Access Code when you schedule your New Patient Appointment

Complete the MyChart Family Medicine History Questionnaire

- Completing this questionnaire will ensure your chart is ready for your appointment with your new provider
- Questionnaire must be filled out at least 24 hrs prior to your appointment. If unable to complete, please contact the clinic.

Complete the MyChart Pre-Check before your New Patient Appointment

- MyChart Pre-Check is available up to 4 days before your appointment
- Update your medication list, pharmacy, allergies & demographics during MyChart Pre-Check

Important information for New Patients

- If you are unable to keep your appointment **PLEASE** contact the clinic **at 360.683.5900 as soon as you can** to reschedule.
- New patients that no show or cancel appointments with less than 24 hours' notice may not be allowed to reschedule.

We appreciate your help in making this a successful experience for you.

***What is MyChart??**

MyChart is an online patient portal available on your computer or through an App allowing you to have more access to your care team through:

- Secure messaging (all messages become part of your legal medical record)
- Viewing lab and imaging test results
- Requesting prescription renewals
- Updating your health history
- Paying your bill
- Schedule non urgent appointments

When you schedule your appointment, you will receive more information on how to access and use MyChart.

JAMESTOWN FAMILY HEALTH CLINIC

PLEASE PRINT
Patient Registration Form

PATIENT INFORMATION

NAME: FIRST	MIDDLE	LAST	
PREVIOUS NAME(S)		**PREFERRED NAME**	
DATE OF BIRTH	**LEGAL GENDER:** FEMALE MALE	**IDENTIFIED GENDER:** FEMALE MALE	**SOCIAL SECURITY #**
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)	**CITY**	**STATE**	**ZIP**
HOME #	**CELL #**	**WORK #**	
OK TO LEAVE DETAILED MESSAGES ON VOICEMAIL? YES NO	**EMAIL**		

ETHNICITY (CIRCLE ONE)	HISPANIC OR LATINO	NON HISPANIC OR LATINO	DECLINE				
RACE (CIRCLE ONE)	AFRICAN AMERICAN	ASIAN	ALASKAN NATIVE/NATIVE AMERICAN	CAUCASIAN	PACIFIC ISLE	OTHER/MULTI	DECLINE

PREFERRED LANGUAGE:	**INTERPRETER NEEDED** YES	NO	
MARITAL STATUS (PLEASE CIRCLE) SINGLE MARRIED	DIVORCED	WIDOWED	DOMESTIC PARTNER
EMERGENCY CONTACT: NAME	RELATIONSHIP TO PATIENT	PHONE #	
NAME	RELATIONSHIP TO PATIENT	PHONE #	

EMPLOYMENT STATUS (CIRCLE ONE) FULL TIME	PART TIME	RETIRED	OTHER _____
EMPLOYERS NAME	**ADDRESS**	**PHONE #**	

PARTY FINANCIALLY RESPONSIBLE FOR PATIENT ACCOUNT (CIRCLE ONE)	SELF	OTHER		
IF OTHER, COMPLETE THIS SECTION:	FIRST	MIDDLE	LAST	**RELATIONSHIP TO PATIENT**

MAILING ADDRESS	**CITY**	**STATE**	**ZIP**
PHONE #	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH**	**EMPLOYER**

INSURANCE INFO (CIRCLE ONE)	COMMERCIAL/ GOVERNMENT INSURANCE	AUTO ACCIDENT	WORKERS COMPENSATION
PRIMARY INSURANCE	**PREFIX & ID #**	**GROUP #**	
SUBSCRIBER (circle)	SAME AS PATIENT	SAME AS RESPONSIBLE PARTY	OTHER
IF OTHER:	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #
SECONDARY INSURANCE	PREFIX & ID #	GROUP #	
SUBSCRIBER (circle)	SAME AS PATIENT	SAME AS RESPONSIBLE PARTY	OTHER
IF OTHER:	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #

NAME	DOB	GENDER
LOCAL PHARMACY	MAIL ORDER PHARMACY	

ARE YOU CURRENTLY TAKING ANY MEDICATIONS REGULARLY? *(PRESCRIPTION AND/OR OVER THE COUNTER)*	YES	NO
NAME OF CURRENT MEDICATIONS *(INCLUDING OVER THE COUNTER)*	**DOSAGE** (mg/ml)	**HOW MANY TIMES PER DAY**
Please add additional medications on the back of this form or typed on a separate sheet of paper		

DO YOU HAVE ANY ALLERGIES INCLUDING TO ANY MEDICATIONS?	YES	NO
ALL ALLERGIES	**REACTION**	
Please add additional allergies & reactions on the back of this form or typed on a separate sheet of paper		

PERSONAL MEDICAL HISTORY *(PLEASE CHECK ALL THAT APPLY, LIST OTHERS AS NEEDED)*

DO YOU HAVE, OR HAVE A HISTORY OF, ANY OF THE FOLLOWING

- ☐ Anemia
- ☐ Anesthesia complications
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer type: _____
- ☐ Cataracts
- ☐ Congestive heart failure (CHF)
- ☐ Clotting disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ HIV/AIDS
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Kidney problem
- ☐ Meningitis
- ☐ Myocardial infarction (heart attack)
- ☐ Nerve/muscle disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Stroke/TIA
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Uterus problems
- ☐ Ovarian problems
- ☐ Prostate problems
- ☐ Testicular problems
- ☐ Erectile dysfunction

- ☐ Chicken pox
- ☐ Shingles
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Bipolar disorder
- ☐ Suicide attempt
- ☐ PTSD
- ☐ Head injury
- ☐ Dementia
- ☐ Neuropathy/myopathy
- ☐ Restless leg
- ☐ Headaches
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Immune system problems
- ☐ Skin problems
- ☐ Acid reflux/heartburn/ulcers
- ☐ Crohn disease/ulcerative colitis
- ☐ Celiac disease
- ☐ Liver disease
- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Bladder problems
- ☐ Incontinence

Other: _____
Other: _____
Other: _____
Other: _____
Other: _____

SURGERIES/PROCEDURES/HOSPITAL STAYS

(PLEASE CHECK ALL THAT APPLY, LIST OTHERS AS NEEDED)

- ☐ Appendectomy
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ C-section
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Hernia repair
- ☐ Hysterectomy, Supracervical
- ☐ Hysterectomy, TAH and BSO
- ☐ Hysterectomy, Total
- ☐ Joint replacement
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Vasectomy

Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____

FAMILY HISTORY

IS YOUR FAMILY MEDICAL HISTORY KNOWN? YES NO	IF NO, WERE YOU ADOPTED? YES NO

Relationship	Alive	Deceased	Rheumatoid arthritis	Osteoarthritis	Asthma	Cancer	Diabetes	Heart Failure	Congestive Heart Disease	High Cholesterol	Hypertension	Migraines	Rashes/skin problems	Seizures	Stroke	Thyroid Disease	Other: ____	Other: ____	Other: ____	Other: ____	Other: ____	Other: ____	Other: ____	Other: ____
Mother																								
Father																								
Sister(s)																								
Brother(s)																								
Maternal Grandmother																								
Maternal Grandfather																								
Paternal Grandmother																								
Paternal Grandfather																								

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? YES Not Currently NO	**IF YES, HOW MANY PER WEEK:** Wine _____ Beer _____ Shots of Liquor _____

ARE YOU SEXUALLY ACTIVE? YES Not Currently NO	**Birth Control Method?** _____	**PARTNER PREFERENCE?** FEMALE MALE BOTH

DO YOU USE MARIJUANA? YES NO	**DO YOU USE STREET DRUGS?** YES NO	**IF YES, WHAT KIND?** Anti-Anxiety Meds Amphetamines
Barbiturates Cocaine Heroin Inhalants LSD Methamphetamines Narcotics Nitrous oxide PCP IV Other: _____		

DO YOU USE TOBACCO? NEVER YES FORMER	**WHEN DID YOU START USING TOBACCO?** _____	**HOW MANY PACKS PER DAY?** _____
IF YES, WHAT TYPE? *Circle all that apply* CIGARETTES CIGAR PIPE E-CIGARETTE SNUFF CHEW	**IF FORMER, WHAT YEAR DID YOU QUIT?** _____	

ARE YOU CURRENTLY PREGNANT? YES NO	**HAVE YOU EVER BEEN PREGNANT?** NO YES	**IF YES, HOW MANY TIMES?** _____	**# OF LIVE BIRTHS** _____

JAMESTOWN FAMILY HEALTH CLINIC

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: **Date of Birth:**

My signature below gives permission to the person(s) listed to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of my medical records will require a signed HIPAA compliant release of information authorization. This permission will be considered ongoing until I state otherwise in writing.

NAME & RELATIONSHIP TO PATIENT	PHONE NUMBER	WHAT IS ALLOWED TO BE DISCLOSED (E.g. Pick up Rx, test results, etc.)	OK TO LEAVE DETAILED MESSAGE?	
			Yes	No

Patient or Legal Representative Signature Date

Printed Name of Patient or Legal Guardian Relationship to patient (if not self)

No Show/Late Cancellation Policy

- As a new patient to Jamestown Family Health Clinic if you, No Show or Cancel your first appointment with less than 24 hours' notice (Late Cancel) we reserve the right to not schedule another new patient appointment
- Established patients of Jamestown Family Health Clinic if you No Show/Late Cancel 3 or more we reserve the right to discharge you as a patient and not schedule you for any further appointments with our clinic
- We ask that you give 24-hour notice for cancellation of all scheduled appointments

Medication Renewal Policy*

- It is your responsibility to plan ahead so you do not run out of medications as this can be dangerous to your health
- Please allow up to 72 hours for us to process all renewal requests
- For all new problems, please make an appointment to see your provider or care team member
- For ***ALL*** controlled substances, you must make an appointment with your provider for a renewal

**Please read the complete Medication Renewal Policy in the Patient's Rights, Responsibilities, and Policies booklet.*

I have read the above policies and have been given a copy of the Patient's Rights, Responsibilities, and Policies. I understand even if I decline to sign and/or accept a copy of the Patient's Rights, Responsibilities, and Policies I am still required to follow ***ALL*** Clinic policies.

Patient or Legal Representative Signature Date

Printed Name of Patient or Legal Guardian Relationship to patient (if not self)

JAMESTOWN FAMILY HEALTH CLINIC

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Jamestown Family Health Clinic 808 N 5th Ave Sequim, WA 98382 ph. 360-683-5900 fax 360-582-4800

Patient Name _____Date of Birth _____ Previous Name_____

Mailing Address _____City _____ ST _____ ZIP _____ Phone _____

I authorize the following organization to release information as stated below from my patient health information record:

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
_____ Organization/Provider _____ Mailing Address City St ZIP _____ Phone Fax	Jamestown Family Health Clinic 808 N. 5th Ave, Sequim, WA 98382 PH: 360-683-5900 FAX: 360-582-4800 ***PLEASE DO NOT SEND RUN-ON RECORDS*** ***OR RECORDS PRINTED FRONT & BACK***

PURPOSE OF RELEASE

□ Transfer of Care □ Continuing Care □ Personal Use □ Legal □ Insurance Claim

INFORMATION TO BE RELEASED

☐ **All medical records for the last two years** ☐ **All medical records**
☐ **Only health records from dates: _____to _____**
☐ **Other (Labs, Pathology, EKG, Radiology): _____**
☐ **Only Health Care records pertaining to: _____**

SENSITIVE INFORMATION

To ***EXCLUDE*** any of the following information, INITIAL all that apply

_____ Mental health or Psychiatric Disorder _____ STD or STI (Sexually transmitted disease or infection)
_____ Drug and/or Alcohol abuse _____ HIV/AIDS Virus

Patient Rights: I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the Jamestown Family Health Clinic based upon this authorization. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

This authorization will expire 1 year from the date signed below unless another date or event is entered here_____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

_____

Signature of Patient or Legally Responsible party DATE (MM/DD/YYYY)

_____

Relationship to patient, if not signed by patient

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy related services and sexually transmitted diseases or infections, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

_____ _____

Signature of Minor Patient DATE (MM/DD/YYYY)