JAMESTOWN
FAMILY HEALTH CLINIC

808 North 5th Ave,
Sequim, WA 98382
Ph. (360) 683-5900 Fx. (360) 582-4800

**Thank you for your interest in becoming 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.

## 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*

- **Refills of controlled substances such as** *Opioids, benzodiazepines, or other high-risk medications* **will not be given during your new patient appointment.**
- 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.

### *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.

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# PLEASE PRINT

## PATIENT INFORMATION

**NAME:** FIRST MIDDLE LAST

**PREVIOUS NAME(S)** | **PREFERRED NAME**

**DATE OF BIRTH** | **LEGAL GENDER:** FEMALE MALE | **IDENTIFIED GENDER:** FEMALE MALE | **SOCIAL SECURITY #**

**MAILING ADDRESS** **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 | **NAME OF TRIBE AFFILIATION** | **ENROLLED AS** (CIRCLE ONE) CITIZEN OR DESCENDANT

**MARITAL STATUS** (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

**EMERGENCY CONTACT:** 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 NAME:** (if other than patient)

RELATIONSHIP TO PATIENT | DATE OF BIRTH | SOCIAL SECURITY #

**SECONDARY INSURANCE** | **PREFIX & ID #** | **GROUP #**

**SUBSCRIBER NAME:** (if other than patient)

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 |
|---|---|---|
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***Please add additional medications on the back of this form or typed on a separate sheet of paper***

**DO YOU HAVE ANY ALLERGIES INCLUDING ANY MEDICATIONS?** YES NO

| ALL ALLERGIES | REACTION |
|---|---|
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***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: _____

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** _____

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**A note to prospective patients of Jamestown Family Health Clinic who are prescribed opioid pain medications, from their current or past healthcare providers.**

We are pleased that you have chosen to seek care at JFHC. Fully understanding, anticipating, and planning for your initial visit is the best way to ensure you experience a seamless, safe, and satisfactory transition in your care.

Establishing primary care at JFHC is not a guarantee that we will continue to prescribe medications in the same manner or dosing as your previous healthcare providers. The continued use of opioid pain medications, in the treatment of chronic pain conditions, first requires a comprehensive evaluation by your JFHC provider. Your initial visit, related to chronic pain management, includes a complete review of past medical, surgical, medication, social, family, drug, and alcohol use histories, along with an appropriate pain focused physical examination.

During your first or subsequent visit to JFHC, your provider will review your medication list in the context of your whole patient care at JFHC. We are a Family Medicine Clinic and do not offer Pain Specialty services separate from our patient's primary care needs. Patients for whom opioid pain management is their primary healthcare need may be directed to seek care at a specialty clinic.

For JFHC to provide appropriate and safe chronic pain management, new patients are required to supply JFHC with outside records pertinent to your pain management history. This includes chart notes, treatment plans, and any imaging reports (x-rays, MRIs, CT scans, other) previously obtained in the evaluation of your pain conditions. For any records, not readily available in our Epic electronic health record, you will need to complete Release of Information forms, available at our front desk.

Consideration for refills of your current opioid pain medications is contingent upon your JFHC provider having full access to such records prior to or at the time of your initial visit. To avoid a possible disruption in your pain management regimen, please take the time to ensure your records are available to us at the time of your first visit.

Thank you for choosing JFHC for your ongoing primary healthcare needs.

Paul Cunningham, MD
Chief Medical Officer, JFHC

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Jamestown Family Health Clinic is a family practice clinic that offers pain management services to our patients on a case-by-case basis. To be considered for pain management, you will be required to complete an Initial Chronic Opioid Therapy packet and provide medical records from any healthcare provider that has treated your chronic pain. Once you return your packet, it will be reviewed along with your previous medical records to determine if you are an appropriate candidate for chronic pain management at our clinic. If your case is complex, we may refer you to a specialty pain clinic or advise that you remain with your current pain management provider. It is important for you to maintain care with your current pain management team until your case has been reviewed and accepted.

**Are you currently prescribed opioid medications?** **Yes** ☐ **No** ☐

**Will you be requesting pain management services at Jamestown?** **Yes** ☐ **No** ☐

**Have you ever seen a pain specialist?** Yes ☐ No ☐

If you have records with a pain specialist, please complete records release below.

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

**Patient Name** _____ **Date of Birth** _____

**Previous Name**_____

**INFORMATION TO BE RELEASED FROM:**

_____
Organization/Provider

_____
Mailing Address City St ZIP

_____
Phone Fax

**INFORMATION TO BE RELEASED TO:**

*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***

**INFORMATION TO BE RELEASED:**

Last two years' worth of all medical records: Records to include psychiatric disorders/mental health, drug and/or alcohol use and treatment.

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

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

**PURPOSE OF RELEASE:** ☐ Continuing Care ☐ Transfer of Care

**Patient Notice**: I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes chronic pain management, mental health, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from disclosing this information.

I understand that I do not have to sign this authorization 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 to Jamestown Family Health Clinic Attn: Administration. If I did, it would not affect any actions already taken based upon this authorization.

_____

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

_____

**Relationship to patient, if not signed by patient**

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## 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. This form replaces any previously signed PHI at Jamestown Family Health Clinic and should be considered ongoing until I state otherwise in writing.

| NAME & RELATIONSHIP TO PATIENT | PHONE NUMBER | WHAT IS ALLOWED TO BE DISCLOSED (E.g. Discuss health, pick up RX, test results, etc.) | OK TO LEAVE DETAILED MESSAGE? | |
|---|---|---|---|---|
| | | | Yes | No |
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### 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 legal representative (If signed by someone other than patient)

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## AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name _____Date of Birth _____ Previous Name_____

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:** |
|---|---|
| _____<br>Organization/Provider<br>_____<br>Mailing Address City St ZIP<br>_____<br>Phone Fax | Jamestown Family Health Clinic<br>808 N. 5th Ave, Sequim, WA 98382<br>PH: 360-683-5900 FAX: 360-582-4800<br>***PLEASE DO NOT SEND RUN-ON RECORDS***<br>***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)