



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.



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

PERSONAL MEDICAL HISTORY <small>(PLEASE CHECK ALL THAT APPLY, LIST OTHERS AS NEEDED)</small>			SURGERIES/PROCEDURES/HOSPITAL STAYS		
DO YOU HAVE, OR HAVE A HISTORY OF, ANY OF THE FOLLOWING			<small>(PLEASE CHECK ALL THAT APPLY, LIST OTHERS AS NEEDED)</small>		
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	Anesthesia complications	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	Brain surgery
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Breast surgery
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	CABG
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Cholecystectomy
<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>	Colon surgery
<input type="checkbox"/>	Cancer type: _____	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	Cosmetic surgery
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	C-section
<input type="checkbox"/>	Congestive heart failure (CHF)	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	Eye surgery
<input type="checkbox"/>	Clotting disorder	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Fracture surgery
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Neuropathy/myopathy	<input type="checkbox"/>	Hernia repair
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Restless leg	<input type="checkbox"/>	Hysterectomy, Supracervical
<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Hysterectomy, TAH and BSO
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Hysterectomy, Total
<input type="checkbox"/>	GERD	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	Joint replacement
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Small intestine surgery
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Spine surgery
<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Hyperlipidemia (high cholesterol)	<input type="checkbox"/>	Immune system problems	<input type="checkbox"/>	Tubal ligation
<input type="checkbox"/>	Hypertension (high blood pressure)	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	Valve replacement
<input type="checkbox"/>	Kidney problem	<input type="checkbox"/>	Acid reflux/heartburn/ulcers	<input type="checkbox"/>	Vasectomy
<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Crohn disease/ulcerative colitis		Other: _____
<input type="checkbox"/>	Myocardial infarction (heart attack)	<input type="checkbox"/>	Celiac disease		Other: _____
<input type="checkbox"/>	Nerve/muscle disease	<input type="checkbox"/>	Liver disease		Other: _____
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Cirrhosis		Other: _____
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Gallstones		Other: _____
<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	Hepatitis		Other: _____
<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	Kidney stones		Other: _____
<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>	Bladder problems		Other: _____
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Incontinence		Other: _____
<input type="checkbox"/>	Tuberculosis		Other: _____		Other: _____
<input type="checkbox"/>	Uterus problems		Other: _____		Other: _____
<input type="checkbox"/>	Ovarian problems		Other: _____		Other: _____
<input type="checkbox"/>	Prostate problems		Other: _____		Other: _____
<input type="checkbox"/>	Testicular problems		Other: _____		Other: _____
<input type="checkbox"/>	Erectile dysfunction		Other: _____		Other: _____

IS YOUR FAMILY MEDICAL HISTORY KNOWN?										IF NO, WERE YOU ADOPTED?														
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 _____
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ARE YOU SEXUALLY ACTIVE?	YES	Not Currently	NO	Birth Control Method? _____	PARTNER PREFERENCE?	FEMALE	MALE	BOTH
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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



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 <input type="checkbox"/>	No <input type="checkbox"/>
Will you be requesting pain management services at Jamestown?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever seen a pain specialist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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	_____ STD or STI (Sexually transmitted disease or infection)
_____ Drug and/or Alcohol abuse and Treatment	_____ 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 _____



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

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)



AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name (Print) _____ Date of Birth _____

Previous Name (Print) _____ Phone _____

INFORMATION TO BE RELEASED FROM:

Organization/Provider (Required) _____

Mailing Address _____ City (Required) _____ State (Required) _____ ZIP _____

Phone (Required) _____ 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

PURPOSE OF RELEASE: ☐ Transfer ☐ Continuation of Care ☐ Mutual Exchange

INFORMATION TO BE RELEASED:

☐ **Most recent 2 years of all medical records, as well as the following reports regardless of date.**

- Colonoscopy Reports and Pathology
- Mammogram/Breast Imaging
- Dexa/Bone Density Study
- PAP Results

☐ **Other:** Specific health information relating to the following treatment or dates: _____

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

***INITIAL ONE OF THE BELOW**

____ **YES**, I consent to release this information to my Jamestown provider.

____ **NO**, I do not consent to the release of this information, and I understand this may affect my care.

This authorization will expire 1 year from the date signed below UNLESS another date or event is entered here _____

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: HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, 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 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 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 SIGNED (MM/DD/YYYY)

Printed Name

Relationship to patient, if not signed by patient

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS-Age 13/14 and older

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 SIGNED (MM/DD/YYYY)