Eagle Point Medical Center

Bear Creek Clinic, PC
PO Box 550
Eagle Point, OR 97524

PATIENT INFORMATION
Please Print Clearly
If you need help with this form, tell the receptionist.

How did you find out about Eagle Point Medical Center?

Last Name of patient
First Name MI
Date of Birth Age
Occupation
Lives With (Name)
Social Security No.
Ethnicity Religion
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employed? ☐ Yes ☐ No Student? ☐ Full Time ☐ Part Time Employer/ School
Name of Guarantor if patient is a minor
In case of EMERGENCY notify:
Name of closest relative not living with you.

Street Address
P. O. Box
City
State Zip
Phone Home Message
Work Pager/Cell
Email
Patient/Guarantor D.L #
Phone ( )
Phone ( )

INSURANCE and Financial Information We require a copy of your drivers license to establish identity

Do you have Medical Insurance or Medical Card? ☐ Yes ☐ No If No, make payment arrangements at window.

If Yes, Please give us your card(s) & driver license so we can make copies for our records

Name of Plan: ☐ Medicare ☐ Oregon Health Plan ☐ Other - Name of Plan
Name of Responsible Party / Insured:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Address: ☐ Same as Patient
OR
Insurance ID #
Phone - Home ( )
Work ( )
Employed By (Insurance Plan Through)

AUTHORIZATION FOR TREATMENT, BILLING OF INSURANCE AND RELEASE OF INFORMATION:

I HEREBY CONSENT TO TREATMENT BY CLINIC PROVIDERS FOR MYSELF OR THE PERSON LISTED ABOVE.
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY OR THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE OR OTHER CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.
I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT, INCLUDING HEALTH INSURANCE AND OTHER MEDICAL PLANS.

X
SIGNATURE (Date) Relationship to Patient above

List ALL MEDICATIONS that you are now taking or that you usually take. Include all prescriptions and over the counter medications.

Name of MEDICATION, Strength, and Frequency INCLUDE SUPPLEMENTS AND HERBAL Name of MEDICATION, Strength, and Frequency

22.
23.
24.
25.
26.
27.
28.
29.
30.
31.

Do you have any DRUG ALLERGIES? ☐ Yes ☐ No If YES, please list them below.

32.
33.
34.
35.

Please Continue on Back

Last, First Name patient _____ Date of Birth _____

36. Do you use Tobacco? ☐ No ☐ Yes Type? _____
How much per day? _____ Quit? ☐ No ☐ Yes When? _____
37. Do you drink Coffee? ☐ No ☐ Yes Cups per day? _____ Cola? ☐ No ☐ Yes Cups per day? _____
38. Do you drink Alcohol? ☐ No ☐ Yes Type _____ Amount per Day _____ per Week _____
39. Do you use diet Medications? ☐ No ☐ Yes Type and Amount? _____
Do you use "street" drugs? ☐ No ☐ Yes Type and Amount? _____
40. Are you ☐ Male OR ☐ Female
41. Have you ever had any liver disease? ☐ No ☐ Yes When? _____
42. Have you ever had any kidney disease? ☐ No ☐ Yes When? _____

Please list each serious medical and surgical illness you have had, the date of onset, and the last doctor who treated you for the condition.
MAJOR ILLNESSES This should include such things as high blood pressure, cancer, pneumonia, diabetes, heart disease, asthma, etc.

43. _____ Date _____ Doctor _____
44. _____ Date _____ Doctor _____
45. _____ Date _____ Doctor _____
46. _____ Date _____ Doctor _____
47. _____ Date _____ Doctor _____

IMMUNIZATIONS

A. ADULT

	Date		Date
48. Pneumovax (Pneumonia)	_____	Others	_____
49. Flu Vaccine	_____		_____
Tetanus	_____		_____

B. PEDIATRIC (Children)

Please give us your child's immunization record to copy for our records.

HOSPITALIZATIONS and SURGERY. (List the times you have been in the hospital for a medical problem or surgery (at least overnight)
DIAGNOSIS OR PROCEDURE

50. _____ Date _____ Doctor _____
51. _____ Date _____ Doctor _____
52. _____ Date _____ Doctor _____
53. _____ Date _____ Doctor _____
54. _____ Date _____ Doctor _____
55. _____ Date _____ Doctor _____
56. _____ Date _____ Doctor _____

List DIAGNOSTIC PROCEDURES you have had such as Pap Tests, Mammograms, Colonoscopy, Complete Physical Exams, etc.

57. _____ Date _____ Doctor _____
_____ Date _____ Doctor _____

Please give your FAMILY HISTORY of medical problems, such as diabetes, heart trouble, high blood pressure, stroke, cancer, bleeding diseases, tuberculosis, gout, arthritis, kidney disease, convulsive disorders, suicide, or other significant problems.

58 Father: If living, give age _____ health problems _____
If dead, age at death _____ cause of death _____
59 Mother If living, give age _____ health problems _____
If dead, age at death _____ cause of death _____
60 Brothers and Sisters Total _____ Dead _____ Causes _____
Other Health Problems _____
61 Children: Total _____ ages _____ Illnesses _____

AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION I authorize **Bear Creek Clinic, PC/Eagle Point Medical Center** to use and disclose a copy of the specific health information described below regarding:

_____

(NAME OF INDIVIDUAL) (DATE OF BIRTH)

consisting of: _____

_____

(SPECIFICALLY DESCRIBE INFORMATION TO BE USED/DISCLOSED)

to: _____

(NAME AND ADDRESS OF RECIPIENT OR RECIPIENTS)

for the purpose of: _____

_____

(SPECIFICALLY DESCRIBE EACH PURPOSE FOR DISCLOSURE, OR STATE "AT THE REQUEST OF THE INDIVIDUAL" IF THIS AUTHORIZATION IS INITIATED BY THE INDIVIDUAL AND THE INDIVIDUAL DOES NOT, OR ELECTS NOT TO, PROVIDE A STATEMENT OF PURPOSE)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information

_____ Mental health information

_____ Genetic testing information

_____ Alcohol/chemical dependency diagnosis, treatment, or referral information

_____ Sexually transmitted disease information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

SIGNATURE I have read this authorization and I understand it. Unless revoked, this authorization expires:

_____

(INSERT EITHER APPLICABLE DATE OR EVENT)

By: _____ Date: _____

(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority:

_____

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to **Kathy Finley, FNP** at **Eagle Point Medical Center, P.O. Box 550, Eagle Point, OR 97524** and state you are revoking this authorization.

ACKNOWLEDGMENT AND CONSENT

I understand that Eagle Point Medical Center, Bear Creek Clinic, PC (referred to below as "This Practice") will use and disclose **health information** about me.

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

I understand and agree that This Practice may **use and disclose** my health information in order 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 of my health care; and
- perform various office, administrative and business functions that support my physician'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 health 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 Practices 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 or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception

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

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Name (Print) _____

By:_____ Date:_____
(Patient Signature)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

Patient Name: _____ Date: _____

Please answer the following questions by checking the space next to the appropriate answer:

Race:

___ Asian ___ Black ___ Hispanic/Latino ___ Native American

___ Native Hawaiian ___ White ___ Other_____

___ Unknown/Refused

Ethnicity:

___ Hispanic ___ Non Hispanic ___ Unknown

Language:

___ Arabic ___ Chinese ___ English ___ Japanese ___ Spanish

___ Russian ___ Other: _____

Nationality:

___ American ___ British ___ Chinese ___ French ___ German

___ Mexican ___ Russian ___ Spanish

___ Other: _____

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

Name of Patient _____ Current Address _____

City State Zip _____ Date of birth _____

Home Phone _____ Work Phone _____ Social Security # _____

I AUTHORIZE RELEASE OF MEDICAL INFORMATION FROM:

Name of Clinic/Facility _____

Name of Provider _____

Address _____

City State Zip _____

SEND RECORDS TO:

EAGLE POINT MEDICAL CENTER

Name of Facility

Name of Provider

Address

City State Zip

275 LOTO STREET
PO BOX 550
EAGLE POINT, OR 97524
PHONE: 541/ 830-0333
FAX: 541/ 830-0863

PURPOSE OF RELEASE OF MEDICAL INFORMATION (PLEASE CHECK BELOW):

☐ Change of Physician/Clinic ☐ Referral/Consultation ☐ Other _____

PERMISSION TO FAX INFORMATION: ☐ Yes ☐ No

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand that confidentiality at the receiving end can not always be guaranteed.

BY INITIALING THE SPACES BELOW, I SPECIFICALLY AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL RECORDS, IF SUCH RECORDS EXIST:

____ Medical Records needed for continuity of care
____ Transcribed Hospital records
____ Laboratory reports
____ Pathology reports
____ Diagnostic Imaging reports
____ Other _____

____ All medical records - I understand there may be a charge to me for this_____
____ Clinician office chart notes
____ Billing statements
____ Dental records
____ Medication summary

____ Most recent five year history
____ Emergency & Urgent care records
____ Physical Therapy records
____ Billing statements

PROTECTED OR SENSITIVE INFORMATION: Must be initialed below to be included in other documents.

____ HIV/AIDS related records
____ Mental Health information
____ Genetic testing information
____ Drug /alcohol diagnosis, treatment or referral information - Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. _____

____ This authorization is limited to the following treatment: _____

____ This authorization is limited to the following time period: _____

____ This authorization is limited to workers compensation claim for injuries of _____ date.

_____ _____ _____

Signature of patient or person authorized by law | Relationship to Patient | Date

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.