PATIENT INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Race	Religion	E-mail Address
Daytime Phone	Marital Status	DOB	Social Security #	Gender
Mother's Name (If patient is a minor)	Father's Name (If patient is a minor)

GUARANTOR	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Relationship to Patient	DOB	Social Security #	Gender
Employer			
Employer's Address	City	State	Zip
Employer's Telephone Ext.	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown		

PATIENT EMPLOYMENT	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown
Occupation	Employer
Address	City	State	Zip
Employer's Telephone Ext.	Employer's Telephone Ext.

PRIMARY INSURANCE	Primary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

SECONDARY INSURANCE	Secondary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

⇨ SEE BACK SIDE

Patient Consent and Registration - Orcas Family Health Center

David C. Shinstrom, MD
Jennifer Utter, PA-C
Karen Orr, PA-C

NEXT OF KIN INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

PERSON TO NOTIFY	Last Name	First Name	Middle Initial
Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

MEDICAL CONSENT

I consent to all medical and surgical treatment, laboratory, diagnostic imaging and other medical procedures performed and prescribed by the health care provider during clinic visits.

_____ _____

Signature *Date/Time*

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

_____ _____

Signature *Date/Time*

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

_____ _____

Signature *Date/Time*

MEDICARE PATIENTS ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE TO PROVIDER & PATIENTS

Name of beneficiary: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished to me at Island Hospital Family Care Clinics. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature *Date/Time*

Orcas Family Health Center
David C. Shinstrom, MD
Jennifer Utter, PA-C
Karen Orr, PA-C

Adult History Information

Patient Name: _____ Date of Birth: _____ Date: _____

To help us provide you with the best care, please fill out this form to the best of your ability. If you feel uncomfortable or confused with the any of the questions, please leave them blank and inform your provider of any concerns. Thank you.

Allergies to foods, substances, or medications: | **Type of reaction:**

_____ _____
_____ _____
_____ _____

Prescribed, over-the-counter, and supplemental medications, including vitamins:

_____
_____
_____
_____
_____

Personal Medical History: Please check any box that applies

☐ **No Known Medical History**

Cancer:

	Year of Onset:
☐ Bladder Cancer	
☐ Blood Cancer	
☐ Brain Cancer	
☐ Breast Cancer	
☐ Cervical Cancer	
☐ Colorectal Cancer	
☐ GI Cancer	
☐ Head/Neck Cancer	
☐ Kidney Cancer	
☐ Leukemia	
☐ Liver Cancer	
☐ Lung Cancer	
☐ Lymphoma	
☐ Melanoma	
☐ Musculoskeletal Cancer	
☐ Oral Cancer	
☐ Ovarian Cancer	
☐ Pancreatic Cancer	
☐ Prostate Cancer	
☐ Skin Cancer	
☐ Stomach Cancer	
☐ Thyroid Cancer	
☐ Uterine Cancer	
☐ Other Cancer:	
_____	

Cardiovascular:

	Year of Onset:
☐ Abdominal Aortic Aneurysm	
☐ Aortic Regurgitation	
☐ Aortic Stenosis	
☐ Atrial Fibrillation	
☐ Cardiac Arrhythmias	
☐ Carotid	
☐ Coronary Artery Disease	
☐ Deep Vein Thrombosis	
☐ Heart Failure- Diastolic	
☐ Heart Failure- Systolic	
☐ Hyperlipidemia	
☐ Hypertension	
☐ Myocardial Infarction	
☐ Pacemaker	
☐ Peripheral Vascular Disease	
☐ Pulmonary Embolism	
☐ Pulmonary Hypertension	
☐ Other Cardiovascular Hx:	
_____	

Endocrine:

	Year of Onset:
☐ Diabetes Mellitus	
☐ Diabetes Isipidus	
☐ Graves Disease	
☐ Hyperthyroidism	
☐ Hypothyroidism	
☐ Low Testosterone	
☐ Pituitary Adenoma	
☐ Thyroid Nodule	
☐ Other Endocrine History:	
_____	

Gastrointestinal:

	Year of Onset:
☐ Barrett's Disease	
☐ Cirrhosis	
☐ Colitis	
☐ Colon Polyps	
☐ Crohn's Disease	
☐ Diverticular Disease	
☐ Esophageal Ring/Web	
☐ Gastric Ulcer	
☐ Gastroparesis	
☐ GERD	
☐ GI Bleeding	
☐ Gluten Enteropathy	
☐ Hemorrhoids	
☐ Hepatitis C	
☐ Irritable Bowel Disease	
☐ Liver Disease	
☐ Pancreatitis	
☐ Peptic Ulcer Disease	
☐ Ulcerative Colitis	
☐ Other Gastrointestinal Hx:	
_____	

Genetic:

	Year of Onset:
☐ BRCA	
☐ Cystic Fibrosis	
☐ Down Syndrome	
☐ Polycystic Kidney Disease	
☐ Other Genetic History:	
_____	

Genitourinary:

	Year of Onset:
☐ Benign Prostatic Hypertrophy	
☐ Elevated PSA	

Genitourinary: (Cont.)

	Year of Onset:
☐ Fecal Incontinence	
☐ Frequent UTI	
☐ Hematuria	
☐ Hemodialysis	
☐ Kidney Disease	
☐ Kidney Failure	
☐ Kidney Stones	
☐ Peritoneal Dialysis	
☐ Prostate Nodule	
☐ Proteinuria	
☐ Urinary Incontinence	
☐ Other Genitourinary Hx:	
_____	

Gynecologic: (females only)

	Year of Onset:
☐ Abnormal Pap	
☐ Chlamydia	
☐ Dyspareunia	
☐ Endometriosis	
☐ Fibroids	
☐ Genital Warts	
☐ Gonorrhea	
☐ Heavy Menstrual Cycles	
☐ Herpes/HSV	
☐ Human Papillomavirus	
☐ Inferiliity	
☐ Irregular Menstrual Cycles	
☐ Ovarian Cysts	
☐ Painful Menstrual Cycles	
☐ Other Gynecologic:	
_____	

HEENT: (Head/eyes/ears/neck/throat)

	Year of Onset:
☐ Blindness – Partial	
☐ Blindness – Total	
☐ Cataracts	
☐ Glaucoma	
☐ Hearing Loss	
☐ Recurrent Ear Infections	
☐ Recurrent Sinusitis	
☐ Retinal Detachment	
☐ Ruptured TM (Eardrum)	
☐ Tinnitus	
☐ Vertigo	
☐ Vocal Cord Paralysis	
☐ Other HEENT History:	
_____	

Orcas Family Health Center
David C. Shinstrom, MD
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Adult History Information

Patient Name: _____ Date of Birth: _____ Date: _____

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Personal Medical History: Please check any box that applies

☐ **No Known Medical History**

Hematology:

	Year of Onset:
☐ Anemia	
☐ Essential Thrombocytosis	
☐ Factor V Leiden	
☐ Hemochromatosis	
☐ Hemophilia	
☐ Myelodysplasia	
☐ Myelofibrosis	
☐ Neutropenia	
☐ Other Coagulation Disorder	
☐ Sickle Cell Anemia	
☐ Thalassemia	
☐ Thrombocytopenia	
☐ Other Hematology Hx:	

_____

Infectious Disease:

	Year of Onset:
☐ Chickenpox	
☐ Hepatitis A, B, or C	
☐ Herpes	
☐ HIV	
☐ Malaria	
☐ Measles	
☐ MRSA	
☐ Mumps	
☐ Polio	
☐ Positive PPD	
☐ Rheumatic Fever	
☐ Rubella	
☐ Syphilis	
☐ Tuberculosis	
☐ Vanco-Resistant Enteroc.	
☐ Other Infectious Disease Hx:	

_____

Musculoskeletal:

	Year of Onset:
☐ Ankle Pain	
☐ Carpal Tunnel	
☐ Cervical Spine Disease	
☐ Chronic Back Pain	
☐ Cubital Tunnel	
☐ Fibromyalgia	

Musculoskeletal: (Cont.)

	Year of Onset:
☐ Foot Pain	
☐ Fractures	
☐ Gout	
☐ Lumbar Spine Disease	
☐ Osteopenia	
☐ Osteoporosis	
☐ Scoliosis	
☐ Shoulder Pain	
☐ Other Musculoskeletal Hx:	

_____

Neurologic:

	Year of Onset:
☐ ADHD	
☐ Autism	
☐ Dementia	
☐ Developmental Delay	
☐ Familial/Benign Tremor	
☐ Headaches	
☐ Migraines	
☐ Multiple Sclerosis	
☐ Parkinson's Disease	
☐ Peripheral Neuropathy	
☐ Restless Leg Syndrome	
☐ Seizures	
☐ Stroke	
☐ Transient Ischemic Attack	
☐ Other Neurologic History:	

_____

Psychiatric:

	Year of Onset:
☐ Anorexia Nervosa	
☐ Anxiety	
☐ Bipolar Disorder	
☐ Bulimia	
☐ Depression	
☐ Personality Disorder	
☐ PTSD	
☐ Schizophrenia	
☐ Substance Abuse	
☐ Other Psychiatric History:	

_____

Respiratory:

	Year of Onset:
☐ Abnormal Chest X-ray	
☐ Allergies/Hay Fever	
☐ Asbestosis	
☐ Asthma	
☐ Chronic Cough	
☐ COPD	
☐ Cystic Fibrosis	
☐ Oxygen Deepened	
☐ Pneumothorax	
☐ Pulmonary Fibrosis	
☐ Sarcoidosis	
☐ Sleep Apnea	
☐ Valley Fever	
☐ Wegener's Granulomatosis	
☐ Other Respiratory Hx:	

_____

Rheumatologic:

	Year of Onset:
☐ Fibromyalgia	
☐ Gout	
☐ Lupus	
☐ Osteoarthritis	
☐ Polymyalgia Rheumatica	
☐ Rheumatoid Arthritis	
☐ Sjögren's Syndrome	
☐ Other Rheumatologic Hx:	

_____

Skin/Integumentary:

	Year of Onset:
☐ Acne	
☐ Actinic Keratosis	
☐ Alopecia	
☐ Eczema	
☐ Melanoma	
☐ Plantar Warts	
☐ Psoriasis	
☐ Rosacea	
☐ Vitiligo	
☐ Other Skin History:	

_____

Orcas Family Health Center
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Patient Name: _____ Date of Birth: _____

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Social History: Please answer or fill in blank as appropriate ☐ No Known Social History

PERSONAL HISTORY:

Education Level:	Less than High School	High School/GED	Some College	2-Year College	4-Year College
	Professional Degree	Masters Degree	Doctoral Degree	Other: _____	
Leisure Activities:					
Travel History:					
Marital Status:	Divorced	Married	Separated	Single (never married)	Widowed Other:
Pets:	Yes / No				
Military Service:	Yes / No	Branch:			
Occupation:					
Faith/Tradition/Religion:					
Household Members/Details:					

SAFETY:

Home Safety:		**Home Safety (continued):**	
Is your water heater temp set below 120?	Yes / No	Do you have a carbon monoxide detector in your home?	Yes / No
Do you have working smoke detectors in your home?	Yes / No	Do you have firearms in your home?	Yes / No
Do you have a fire extinguisher in your home?	Yes / No	Are firearms unloaded and locked?	Yes / No

PERSONAL HISTORY:				
Do you have concerns about your personal safety?	Yes / No	Comments:		
VEHICLE SAFETY:				
Seatbelt use:	Always	Never	Sometimes	Other:
Helmet use:	Always	Never	Sometimes	Other:
Additional Comments:				

SUBSTANCE USE:

TOBACCO USE:				
Tobacco Status:	Current every day smoker	Current some day smoker	Heavy tobacco smoker	Light tobacco smoker
	Former Smoker	Smokeless tobacco user	Unknown if ever smoked	Never smoker
	Smoker, current status unknown	Comments:_____		
Smoking packs/day:				
Smoking/Tobacco history or details:				
Quit status:	Considering quitting	Not considering quitting	Quit date established	Other:
ALCOHOL USE:				
Alcohol intake:	1-2 drinks per day	2+ drinks per day	1-3 drinks per week	Rare/Occasional
	None	Other:_____		
Additional Comments:				

SUBSTANCE USE:						
Substance or recreational drug use:	Amphetamines	Club/designer drugs	Cocaine/crack	Denies use	Hallucinogens	Inhalants
	Injection Drugs	Marijuana	Opiates	Painkillers	Tranquilizers/sedatives	
	None	Other:_____				
Additional Comments:						

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Adult History Information

Patient Name: _____ Date of Birth: _____

To help us provide you with the best care, please fill out this form to the best of your ability. If you feel uncomfortable or confused with the any of the questions, please leave them blank and inform your provider of any concerns. Thank you.

Social History: Please answer or fill in blank as appropriate ☐ **No Known Social History**

DIET AND EXERCISE:

During the past year has your weight?	Remained stable Decreased less than 10 pounds Increased more than 10 pounds
Other:	_____

DIETARY HABITS:

How often do you eat a well balanced diet?	About half the time Daily or most days Rarely or never Other:
How often do you eat fruit and vegetables?	0-1 servings daily 2-4 servings daily 5 or more servings daily Other:
How often do you drink soda/pop?	1-2 drinks per day 2+ drinks per day 1-3 drinks per week Rare/Occasional Never Other: _____
How often do you drink caffeinated beverages?	1-2 drinks per day 2+ drinks per day 1-3 drinks per week Rare/Occasional Never Other: _____
How often do you eat/dine out?	1-3 times a week 4 or more times a week Rarely or never Other:
Additional Comments:	

EXERCISE/PHYSICAL ACTIVITY:

Please list your physical activities/exercise:	
Frequency?	Daily 1-2 times per week 3-4 times per week 5-6 times per week Other:
Duration?	15-30 minutes a day 30-45 minutes a day 45-60 minutes a day 60-90 minutes a day Other: _____

DISABILITIES:

Do you live with any of the following disabilities?	Yes / No (Please circle) Check those that apply and explain
Hearing Deficiencies	☐
Vision Deficiencies	☐
Hemiparesis	☐
Paralyzed/Partially Paralyzed	☐
Paraplegia	☐
Quadriplegia	☐
Other Disabilities	☐

Patient Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY:

☐ **NO KNOWN FAMILY HISTORY**

Please check the medical conditions that run in your family and which family member had the condition:

	Age if still Living	Age at Death	Present Condition or Cause of Death	Cancer (specify)	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Mental Health Issues	Stroke	Other (please specify)
Father											
Mother											
Brother(s)											
Sister(s)											
Maternal Grandfather											
Maternal Grandmother											
Paternal Grandfather											
Paternal Grandmother											
Child											

Additional Comments: _____

_____

_____

_____

SURGICAL HISTORY:

☐ **NO KNOWN SURGICAL HISTORY**

Please list any surgeries/surgical procedures you have had and the approximate date/year:

Type of surgery and location: **Date:**

*Please specify right or left where applicable

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had anesthesia for surgery? ~ Yes / No (circle)

If any complications please explain: _____