SOUTH SOUND FAMILY & SPORTS MEDICINE
PATIENT MEDICAL HISTORY

Name:	Birthdate:	Today's Date:
Single:___ Married:___ Domestic Partner:___ Widowed:___ Divorced:___	Occupation:	Years of Education:

ALLLERGIES:

HABITS

Smoking? Y N Quit _____ Years Ago _____

Packs Per Day _____ How Many Years?

Chewing Tobacco? Y N

Alcohol? Y N Quit _____ Years Ago _____

Amount Per Week:

Caffeine: Y N Amount Per Day _____

Other Drugs? Y N Please Describe:

EXERCISE:

__ No Regular Exercise __ Occasional (once/week)
__ Regular (3 times/week) __ Frequent (daily)
Types of exercise:

Previous Primary Physician:

Other health care providers you currently see:

CURRENT MEDICATIONS AND DOSAGES:

CURRENT MEDICAL PROBLEMS:

SURGERIES/INJURIES AND DATES:

PAST MEDICAL PROBLEMS/HOSPITALZATION

FAMILY HISTORY	LIVING		DECEASED	
	Age	Major Illnesses	Age at Death	Cause of Death
Father				
His Father				
His Mother				
Mother				
Her Mother				
Her Mother				
Brother (s)				
Sister (s)				
Children				

Please check if any immediate family have had:

☐ Asthma	☐ Thyroid problems	☐ Heart disease
☐ Allergies	☐ Kidney problems	☐ High blood pressure
☐ Cancer	☐ Bleeding disorders	☐ Heart attacks
☐ Diabetes	☐ Alcoholism	☐ Strokes
☐ Arthritis	☐ Mental illness	☐ Seizures (epilepsy)

GYNECOLOGIC HISTORY

Number of pregnancies _____ miscarriages _____ abortions _____

Date of last pap smear:

Have you had an abnormal pap smear? Y N Date:

Have you had any sexually transmitted diseases? Y N

Have you had a mammogram? Y N Date:

PREVIOUS HEALTH MAINTENANCE

Date of last complete physical exam: _____ Date of last tetanus booster:_____

Do you get annual flu shots? Y N Have you had a pneumonia shot? Y N Date: _____

Date and place of last blood testing:

Have you ever had a blood transfusion? Y N Date: _____

Do you always wear seatbelts? Y N

Please list things you want to discuss with your provider today:

SOUTH SOUND FAMILY & SPORTS MEDICINE
ACCOUNT REGISTRATION FORM

ACCOUNT # _____

PATIENT INFORMATION

Full Name _____
FIRST MIDDLE LAST

Home Address _____

Billing Address (if different) _____

City, State, Zip _____

Home Phone (___)_____ Work Phone (___)_____

Cell Phone (___)_____

Birth Date _____ Sex: Female _____ Male _____

S.S. # _____ Occupation _____

Employer _____ Driver's License #_____

Employer's Address _____ City _____ St._____ Zip_____

May we call you at work? Yes ____ No ____ May we contact you through email? Yes ____ No ____

Email Address _____ @ _____

Marital Status

- SINGLE ☐
- MARRIED ☐
- DOM. PART. ☐
- DIVORCED ☐
- LEG. SEP ☐
- WIDOWED ☐

SPOUSE, PARENT OR GUARDIAN INFORMATION *Living in the same household as the patient*

Full Name _____
FIRST MIDDLE LAST

Relationship to Patient Parent ____ Guardian ____ Spouse ____ Other (specify) _____

Work/Day Phone (___)_____ Birth Date _____

PARENT NOT LIVING IN PATIENT HOUSEHOLD *Required if child is covered under this parent's Insurance*

Full Name _____
FIRST MIDDLE LAST

Home Address _____

City, State, Zip _____

Home Phone (___)_____ Work/Day Phone (___)_____

EMERGENCY NUMBER *Nearest Relative/Friend outside of your household*

Name _____ Day Phone (___)_____

Relationship to Patient _____ Eve. Phone (___)_____

Name _____ Day Phone (___)_____

Relationship to Patient _____ Eve. Phone (___)_____

DO YOU HAVE:	YES	NO	
	YES	NO	A LIVING WILL
	YES	NO	DURABLE POWER OF ATTORNEY FOR HEALTH CARE
	YES	NO	ADVANCE DIRECTIVE
	YES	NO	DO YOU WISH ADDITIONAL INFORMATION

THE EXISTANCE OR EXECUTION OF A LIVING WILL, DURABLE POWER OF ATTORNEY FOR HEALTH CARE, OR WRITTEN ADVANCE DIRECTIVE IS NOT A CONDITION OF RECEIVING HEALTH CARE SERVICES AND MAY NOT OTHERWISE BE USED TO DISCRIMNATE AGAINST AN INDIVIDUAL.

Signature _____ Date _____

ACCOUNT#

_____

SOUTH SOUND FAMILY AND SPORTS MEDICINE

FAMILY RELEASE FORM

TODAY'S DATE _____

I, _____, authorize South Sound Family & sports Medicine to disclose the following health care information: (please check box)

☐ All health care information in my medical record, this does **NOT** include HIV/STD/Psychiatric/Drug/Alcohol

☐ All health care information in my medical record, this **DOES** include HIV/STD/Psychiatric/Drug/Alcohol

☐ Appointment information

☐ Test results

☐ Other (x-rays, bills, etc.) please specify

_____

_____

Information may be shared with the following individuals:

Name	**Relationships**

_____

Patient Signature

_____

Printed Name

**This authorization is valid until South Sound Family and Sports Medicine receives written revocation from the patient.

This form will be retained in your medical record.

ACCOUNT#

_____

SOUTH SOUND FAMILY AND SPORTS MEDICINE

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting Jenny Blake or Kelli Osborne, Office Managers.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Policies.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of patient Relationship

This form will be retained in your medical record.

Last update ___/___/_____ HIPAA PRIVACY

SOUTH SOUND FAMILY AND SPORTS MEDICINE

INSURANCE INFORMATION

IS THIS INSURANCE THROUGH: ____YOUR EMPLOYER ____SPOUSE EMPLOYER
____DOMESTIC PARTNER ____PARENT'S EMPLOYER ____OTHER

ACCOUNT# _____

Relationship to insurance policy holder:_____(i.e. Self, spouse, parent, or partner)
Date insurance plan began:_____
Insurance policy holder's name:_____
Insurance policy holders' birthdate_____

AUTHORIZATION/RESPONSIBILITY FOR THE TREATMENT OF A MINOR:

I, _____, the parent or legal guardian of my child, _____, authorize and consent to emergency and routine medical treatment and procedures to be performed for my child by licensed medical personnel when deemed necessary or advisable and I cannot be contacted. Regarding financial responsibility for this child, he/she will remain on my account and I will be responsible for his/her medical bills regardless of changes in family situations, (i.e. divorce, custody issues, etc.) until he/she is 18 years of age. I also authorize the release of the minors PHI for payment purposes. Authorization and financial responsibility shall continue and be in full force and effect until revoked in writing by me.

Signature_____ Date_____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY:

I authorize South Sound Family and Sports Medicine or my insurance company to release any PHI information required for processing any insurance claim(s). I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by South Sound Family and Sports Medicine and that I am financially responsible for the full amount of the charges which are not covered by insurance benefits. I also understand that South Sound Family and Sports Medicine will submit claims to by insurance company using the information that I have provided for this purpose, and I agree that I will be responsible for the charges if the insurance company indicates that coverage was not in effect or that I was assigned to a Primary Care Physician (PCP) elsewhere. If being signed by a spouse or partner, I understand that these provisions apply to the patient name above.

Signature_____ Date_____

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH CARE INFORMATION
TO SOUTH SOUND FAMILY AND SPORTS MEDICINE (S.S.F.& S.M.)

PATIENT NAME_____ DATE OF BIRTH_____

PREVIOUS NAME(S) _____ SSN#_____

I. My Authorization

You may use or disclose the following health care information (check all that apply)

☐ All health care information in my medical record, this does NOT include HIV/STD/Psychiatric/Drug/Alcohol

☐ Health care information in my medical record relating to the following treatment or condition

_____

☐ Health care information in my medical record for the date(s) _____

☐ Other (e.g., X-rays, bills,) specify date(s) _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply)

☐ HIV (AIDS virus)

☐ Psychiatric disorders/mental health

☐ Sexually transmitted diseases

☐ Drug and/ or alcohol use

I request and authorize:
CLINIC/PROVIDER NAME_____
ADDRESS_____
CITY_____ST_____ZIP_____
PHONE(_____)_____FAX(_____)_____

To mail the record to:
SOUTH SOUND FAMILY & SPORTS MEDICINE
2960-A LIMITED LANE NW
OLYMPIA WA 98502
TEL: (360) 709-9500 FAX: (360) 754-4517

Reason(s) for this authorization (check all that apply)

☐ at my request

☐ other (specify) _____

☐ check *only* if S.S.F.& S.M. requests the authorization for marketing purposes

☐ check *only* if S.S.F.& S.M. will be compensated for providing health information for marketing purposes.

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed)*

☐ in 90 days from the date signed

☐ on (date) _____

☐ when the following event occurs_____

(NO LONGER THAN 90 DAYS FROM DATE SIGNED)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment.) 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 S.S.F.& S.M. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

*Fill out a revocation form. A form is available at South Sound Family & Sports Medicine; or
*Write a letter to South Sound Family & Sports Medicine

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

SIGNATURE_____ DATE_____

PRINTED NAME_____ RELATIONSHIP_____