DUNES FAMILY HEALTH CARE
Lower Umpqua Hospital District
620 Ranch Road, Reedsport OR 97467
Phone: 541.271.2163 Fax: 541.271.4058

Dear New Patient,

Thank you for your interest in establishing care with Dunes Family Health Care. The following information is provided to help with a smooth transition into our primary care clinic.

This new patient packet contains forms for you to provide your information, demographics, medical and social history, and a release of information request so we can get your previous healthcare records. **Please complete these forms and return them to the front desk at the clinic.**

The front desk will also take a copy of your identification and insurance card(s) and have you review and sign our consent for treatment and several other Lower Umpqua Hospital District policies. Copies of the following policies and notices are available upon request at Dunes Family Health Care and Lower Umpqua Hospital:

- General Consent for Treatment
- HIPAA Notice
- Missed and late Appointments Policy
- Notice of Privacy Practices
- Patient's Rights and Responsibilities
- Notice of Referral Rights

Once your information has been reviewed, you will be contacted and may be given an appointment date and time for your first visit. We **ask you to arrive 15 minutes early for your first visit** to allow time in case any of your information needs to be updated.

Please contact our office promptly if you are unable to keep an appointment at 541-271-2163.

Thank you again for your interest in Dunes Family Health Care. We look forward to getting to know you and being a part of your healthcare team.

Sincerely,

Dunes Family Health Care

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PATIENT INFORMATION AND DEMOGRAPHICS

Name: First ______________________ Middle ___________________ Last _______________________________

Preferred Name (if different) _________________________ Maiden/Other Names __________________________

Date of Birth ______________ Sex assigned at birth: ☐ Male ☐ Female Preferred Pronouns _____________

Address ___________________________________ City ________________ State ___________ Zip __________

Cell Phone (_____) - _____ - _________ ☐ Primary Home Phone (_____) - _____ - _________ ☐ Primary

Email ____ Social Security #: ______ - _____ - _____________

Occupation ____ Employer _________________________________

Primary Language ______________________ Race ______________________ Ethnicity ____________________

RESPONSIBLE PARTY ☐ Same as Patient

Name ____ Date of Birth ______________

Address ___________________________________ City ________________ State ___________ Zip __________

Cell # (_____) - _____ - _________ Home # (_____) - _____ - _________ Email ____________________________

EMERGENCY CONTACT

Name __________________________________ Phone (_____) - _____ - _________ Relation _________________

INSURANCE INFORMATION

Primary

Plan ___________________________________ Payer ID ________________ Phone (_____) - _____ - _________

Address ___________________________________ City ________________ State ___________ Zip __________

Policy # ___________________________ Group # ___________________________

Secondary

Plan ___________________________________ Payer ID ________________ Phone (_____) - _____ - _________

Address ___________________________________ City ________________ State ___________ Zip __________

Policy # ___________________________ Group # ___________________________

Please list any medical facilities where you have received care in the last three (3) years: ___________________

____

____

____

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MEDICAL AND SOCIAL HISTORY

Have you or any relative(s) ever been diagnosed with any of the following **CONDITIONS/DISEASES**?

Condition/Disease	History?	If a relative, who? (mother, father, sister, etc.)
Anemia	☐ Me ☐ Relative ☐ No	
Arthritis	☐ Me ☐ Relative ☐ No	
Asthma / Allergies	☐ Me ☐ Relative ☐ No	
Birth Defect	☐ Me ☐ Relative ☐ No	
Bleeding Disorder	☐ Me ☐ Relative ☐ No	
Cancer or Tumor	☐ Me ☐ Relative ☐ No	
Chronic Pain	☐ Me ☐ Relative ☐ No	
COPD / Emphysema	☐ Me ☐ Relative ☐ No	
Depression / Anxiety	☐ Me ☐ Relative ☐ No	
Diabetes	☐ Me ☐ Relative ☐ No	
Epilepsy or Seizure Disorder	☐ Me ☐ Relative ☐ No	
Glaucoma	☐ Me ☐ Relative ☐ No	
Heartburn / GERD	☐ Me ☐ Relative ☐ No	
Heart Disease	☐ Me ☐ Relative ☐ No	
High Blood Pressure	☐ Me ☐ Relative ☐ No	
High Cholesterol	☐ Me ☐ Relative ☐ No	
Kidney or Bladder Issues	☐ Me ☐ Relative ☐ No	
Mental Illness	☐ Me ☐ Relative ☐ No	
Migraines	☐ Me ☐ Relative ☐ No	
Substance Use Disorder	☐ Me ☐ Relative ☐ No	
Stroke	☐ Me ☐ Relative ☐ No	
Suicide (or attempt)	☐ Me ☐ Relative ☐ No	
Tuberculosis	☐ Me ☐ Relative ☐ No	
Ulcer	☐ Me ☐ Relative ☐ No	
Other:	☐ Me ☐ Relative ☐ No	
Other:	☐ Me ☐ Relative ☐ No	

List any **SURGICAL PROCEDURES** you have had in the past:

Procedure	Date	Doctor	Hospital	City, State
e.g. Appendix removal	*6/17/2010*	*Dr. Smith*	*Lower Umpqua Hospital*	*Reedsport, OR*

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List any **HOSPITALIZATIONS** for any reason other than a surgery listed above:

Reason	Dates	Hospital	City, State
e.g. Asthma exacerbation	*9/15/19 – 9/21/19*	*Lower Umpqua Hospital*	*Reedsport, OR*

Please list any **MEDICATION ALLERGIES**, your reaction to that medication, and when the allergy was diagnosed:

Medication	Reaction	When diagnosed?
e.g. Penicillin	*Hives*	*Age 7 (1997)*

Are you allergic to: Latex? ☐ No ☐ Yes Imaging contrast? ☐ No ☐ Yes Iodine? ☐ No ☐ Yes

Please list any **CURRENT MEDICATIONS AND SUPPLEMENTS** that you take regularly:

Medication	Dose (Strength)	Frequency
e.g. Lisinopril	*10 mg*	*Daily*

Are you adopted? ☐ No ☐ Yes **Do you receive help from a caregiver?** ☐ No ☐ Yes If yes, who? _______________

Household members: ☐ Spouse ☐ Significant other ☐ Family ☐ Children ☐ Friend(s) ☐ Caregiver ☐ None

Housing: ☐ Apartment ☐ House ☐ Condominium ☐ Assisted living ☐ Nursing home ☐ Homeless ☐ Other: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender Identity: ☐ Male ☐ Female ☐ Trans ☐ Gender fluid ☐ Decline to answer ☐ Other: _______________________

Do you drink alcohol? ☐ Never ☐ Currently ☐ Former If yes, how many drinks/week? _______ Quit Date _______

Do you smoke? ☐ Never ☐ Currently ☐ Former If yes - Packs/Day _____ Years smoked _____ Quit Date _______

Do you use e-cigarettes or vape? ☐ Never ☐ Currently ☐ Former If yes - What's in them? _______________________

Do you use other tobacco products? ☐ Never ☐ Currently ☐ Former If yes, please specify: ______________________

Do you use any recreational drugs? ☐ Never ☐ Currently ☐ Former If yes, please specify: _______________________

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize (*facility*) ____ to release a copy of the medical

information for (*patient name*) ____________________________________, birthdate _____/_____/________ to:

DUNES FAMILY HEALTH CARE, 620 Ranch Road, Reedsport, OR 97467, Fax: 541-271-4058.

This information will be used on my behalf for the following purpose(s): CONTINUITY OF CARE.

By **INITIALING** the spaces below, I specifically authorize the release of the following records, if such records exist:

_____ Most recent three (3) year history
_____ Medical records needed for continuity of care
_____ Transcribed hospital records
_____ Laboratory Reports
_____ Emergency and urgent care records
_____ All hospital records (including nursing records and progress notes)
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinician office chart notes
_____ Dental records
_____ Other: _________________________________

SENSITIVE RECORDS

I authorize the following information to be used, disclosed, or received by placing my **INITIALS** next to the information:

_____ Mental health records
_____ Genetic testing information
_____ Alcohol and drug information
_____ HIV/AIDS records

This authorization is limited to the following time period: ____

This authorization is limited to a worker's compensation claim for injuries of: ___________________________

My signature indicates that I authorize the disclosure of the above information. I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits. I understand that I can cancel permission to use and disclose my information at any time in writing. 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. I understand this change will not affect information that has already been shared. I understand that federal and state law protects my health information. However, my information could be shared with agencies or business that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment, or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Guardian/Person Authorized by Law Date