Health First Family Medicine, LLC
2975 SW Cornelius Pass Road, Suite A Hillsboro, OR 97123 (P) 503/372-6123 (F) 503/746-5109

PATIENT REGISTRATION FORM

Patient Name: Social Security Number:

Date of Birth: Gender: Marital Status:

Address:
(Street, City, State, Zip)

Home Phone: Cell Phone:

E-mail Address: Employer:

RESPONSIBLE PARTY: (Complete only if different from patient)

Responsible Party Name: Social Security Number:

Date of Birth: Gender: Relation to Patient:

Address (if different from patient):
(Street, City, State, Zip)

Home Phone: Cell Phone:

E-mail Address: Employer:

WHO TO CALL IN CASE OF EMERGENCY:

Name: ______________________________ Relationship: ____________________

Address: ____
(Street) (City/State/Zip)

Home Phone: (_____) __________-_________ Work Phone: (_____) __________-_________

Cell Phone: (_____) __________-_________

PRIMARY INSURANCE INFORMATION

Plan Name: Relation to Patient:

Member I.D. Number: Group Number:

Policy Holder Name: Policy Holder SSN:

Policy Holder DOB: Policy Holder Gender:

Plan Address:
(Street, City, State, Zip)

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SECONDARY INSURANCE INFORMATION

Plan Name: Relation to Patient:

Member I.D. Number: Group Number:

Policy Holder Name: Policy Holder SSN:

Policy Holder DOB: Policy Holder Gender:

Plan Address:
(Street, City, State, Zip)

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y ____ N____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

ASSIGNMENT OF BENEFITS

I attest that the information I have provided to Health First Family Medicine, LLC is correct and true to the best of my knowledge. I hereby assign any medical and/or surgical benefits to Health First Family Medicine, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I further authorize Health First Family Medicine, LLC to release all information to secure payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician, hospital, pharmacy, or medical care facility to provide all information regarding my medical or pharmaceutical history and treatment to Health First Family Medicine, LLC. I furthermore will allow my pharmacy to supply verification of benefits. I also authorize Health First Family Medicine, LLC to release my medical information to other physicians as needed to facilitate treatment.

Signature: ____ Date: ____________

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Medical History

Patient Name:	Date of Birth:	Age:	Today's Date:
	Birth Place:	Gender:	

Patient's Medical History: Has the patient ever had? (Circle all that apply)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Immediate Family's Medical History: Blood relatives currently have or have ever had? (Circle all that apply

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Family History:

	Age(s)	Living?	Age at Death	Cause of Death or Current Condition
Father	________	Y / N	________	________
Mother	________	Y / N	________	________
Brothers	________	Y / N	________	________
Sisters	________	Y / N	________	________
Child(ren)	________	Y / N	________	________

List All Surgeries and Serious Illnesses:

Surgery/Serious Illness	Year	Hospital/Location
________	________	________
________	________	________

Medication/Food Allergies:

Medication	Reaction
________	________
________	________
________	________

Food	Reaction
________	________
________	________
________	________

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Medications you are Currently Taking: (Including birth control, over the counter, and herbal medications)

Medication	Dose	Frequency
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

Dates of your last:

Blood test/Cholesterol Level: ________________ EKG: ________________
Pap Smear: ________________ Chest X-ray: ________________
Prostate Check: ________________ Mammogram: ________________
Physical Exam: ________________ Tetanus Booster: ________________
Glaucoma Check: ________________ Pneumovax: ________________
Sigmoidoscopy/Stool Check: ________________ Skin Test for TB: ________________

Social History:

Marital Status: ______________ Occupation: ______________ Spouse's Occupation: ______________

Do you smoke? Y or N
If yes, age you started smoking: _______ Year you quit: ________ Packs per day: ________

Illicit drug use? ☐Never ☐Remote ☐Recent ☐Current

How much caffeine do you drink? (Average number of drinks per day)
None 1 2 3 4 ≥5

How much alcohol do you drink? (Average number of drinks per day)
None Rare (<1) Moderate (1-2) High (>2)

Do you exercise?
None Occasional Moderate Frequent

Seat Belt Use? Y or N Smoke Detector in Home? Y or N

Bike Helmet Use? Y or N Fire Extinguisher in Home? Y or N

Have you ever completed an Advance Directive or Living Will? Y or N

Have you requested your medical records from your previous Physician's office? Y or N
If not, Please request a Release of Records form at our front desk.

Thank you for taking the time to complete this form.

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Clinic Family and Friends Authorization Form

Patient Name: ______________________________ Date of Birth: ______________

As a patient of Health First Family Medicine, LLC, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.
I give permission for information related to my current health status to be discussed with:

Name	Relationship	Telephone

The following people are indicated as individuals who can make medical decisions on my behalf if I am unable to make them on my own.

Name	Relationship	Telephone

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

______________________________ Signature

______________________________ Today's Date

☐ I decline to have my medical information discussed with family or friends.

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AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: ____
(Name and Address of physician/medical group)

______________________ ______________________
(Physician/medical group phone number) *(Physician/medical group fax number)*

To use and disclose a copy of medical information described below, regarding:

____
(Name of Patient) *(Date of Birth)*

Consisting of *(Check appropriate box)*:

□ Full Records

-or-

□ Specific Information Only *(Circle all below that apply)*

History & Physical Medications/Therapy Lab/Path/EKG X-ray/Ultrasound

Operative Reports Accident & Injury Immunizations Other: ____________

Protected or sensitive information: I understand that certain information cannot be released with specific authorization as required by State/Federal law. BY INITIALING, I authorize release of the following protected or sensitive information:

____ Drug Abuse Diagnosis/Treatment ____ Mental Health Treatment

____ Alcoholism Diagnosis/Treatment ____ Sexually Transmitted Diseases

____ AIDS/HIV Test Results including related high risk behaviors

To: Health First Family Medicine, LLC

for the purpose of: Consultation and/or Treatment

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: ____________________________ Date:
(Patient)

- OR –

By: ____________________________ Date:
(Patient representative)

Description of Representative's Authority:____________________________