

Please print **A. PATIENT INFORMATION** (We send the bill and medical information here)

Last Name _____ First Name _____ MI _____ Male _____ Female _____ Age _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____
 Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____ Married _____ Single _____ Other _____
 E-mail Address _____ School Name _____
 Employer Name of Person paying This Bill _____ Employer Address _____
 Self _____ Parent _____ Other _____

B. PARENT OR GUARDIAN INFORMATION (College Students list your Parents Address below)

Last Name _____ First Name _____ MI _____ Male _____ Female _____ Age _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____
 Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____ Married _____ Single _____ Other _____
 Employer Name of Person paying This Bill _____ Employer Address _____
 Self _____ Parent _____ Other _____

C. INSURANCE INFORMATION (Please present copy)

Primary Insurance Company _____ Group Number _____ ID Number _____
 Policy Holder Self _____ Parent/Guardian _____ If Other Than Self _____
 Last Name _____ First Name _____ Date of Birth _____
 Secondary Insurance Company _____ Group Number _____ ID Number _____

D. EMERGENCY CONTACT INFORMATION (with address/phone other than own)

Last Name _____ First Name _____ Phone Number _____ Relationship _____
 Address _____ City _____ State _____ Zip _____

E. FINANCIAL / PRIVACY AGREEMENT (Co pays are due the day of service)

PAYMENT OF BENEFITS
 Bellingham Family Health Clinic will bill the patient's insurance provided the necessary information is supplied (ID/insurance card). By signing below, the patient (or parent/guardian):
 -Authorizes payment from their insurance company directly to Bellingham Family Health Clinic.
 -Agrees that after sixty (60) days all unpaid balances become their responsibility.
 -Agrees that charges not covered by their insurance become their responsibility.

MEDICAL RELEASE AUTHORIZATION
 -The insured party or dependent patient (if not minor) must sign on all claims.
Signing authorizes your insurance company, employer, hospitals, the clinic's billing/ collection agency, or health care provider to release any necessary information requested.

I certify that the information I furnish is true and correct, and that I have read, understand and agree to the policies and terms outlined above. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

TERMS
 -Patients with no insurance who cannot pay in full at the time of service must pay 50% and will be billed for the remainder of the balance.
 -A 10% deduction is given if visit paid in full the day of service for private pay clients. (Does not include supplies, medications, or immunizations.)
 -Accounts past due need to call to make arrangements for payment to avoid penalties. Past due accounts may result in termination of services.
 -All products/supplements must be paid in full at the time of service.
 -There will be a \$35.00 fee for any returned checks/VISA charges.
 -The Bellingham Family Health Clinic reserves the right to change the terms/fees without notice.

NO SHOW POLICY
 - A \$35.00 "No Show" fee will be charged for failing to show up on time for a scheduled appointment. 24 hours notice is required to cancel an appointment or fee will be billed.

SIGNATURE _____
 PRINTED NAME _____ DATE _____ / _____ / _____

I have read or been given a copy of the PRIVACY POLICY. I understand and accept it. Yes _____ No _____

HEALTH HISTORY QUESTIONNAIRE (A copy of this form will be kept in your medical record)

Reason for today's visit? _____ _____	Do you have any ALLERGIES to medications Y N (list) _____ _____
What are your past/ current medical problems? _____ _____ _____ _____	Other allergies: _____ Daily Medications or Supplements: _____ _____ _____
Operations/ and Hospitalizations? (Year/ reason) _____ _____	How did you hear about this practice? _____ _____

1. PLEASE LIST DATES 2. WOMEN (CIRCLE) 3. CURRENT SYMPTOMS (PLEASE CIRCLE)

COLONOSCOPY _____ CHEST X-RAY _____ EKG _____ LAST PHYSICAL EXAM _____ Last eye exam _____ MAMMOGRAM _____ (any abnormal) Yes No PAP SMEAR _____ (any abnormal) Yes No IMMUNIZATIONS TETNUS _____ PNEUMONIA _____ HPV _____ HEPATITIS A _____ HEPATITIS B _____ TUBERCULOSIS _____	DATE OF LAST MENSTRUAL PERIOD _____ # of pregnancies _____ # of births _____ DO YOU HAVE CONCERNS ABOUT: Family planning _____ Irregular periods _____ Painful periods _____ Menopausal symptoms _____ Hot flashes _____ Bleeding between periods _____ Painful intercourse _____ Nipple discharge _____ Vaginal discharge _____ Other: _____	<u>GENERAL</u> Change to weight _____ Appetite _____ Sensitive to heat or cold _____ Sexual concerns _____ Fatigue _____ <u>HEART</u> Chest pain or tightness _____ Palpitations _____ Swelling of ankles _____ <u>RESPIRATORY</u> Cough, Wheezing, Shortness of breath, Hoarseness _____ <u>EARS, NOSE, and THROAT</u> Hearing problems, Vision problems, Teeth or Gums, Hay fever or sinus problems _____
		<u>GASTROINTESTINAL</u> Stomach pain, Heartburn, Nausea or vomiting, Diarrhea, Constipation, Blood in Stool _____ <u>URINARY</u> Pain or burning, Frequent urination, Incontinence, _____ <u>MOODS and OTHER</u> Headaches, Insomnia, Anxiety, Depression, Panic attacks, Acne, Skin rashes, Changing moles, Back pain, Arthritis, Body aches, Other: _____

FAMILY HISTORY

Mother: Age if living _____ Health Problems _____
 If deceased, age at death _____ cause: _____
 Father: Age if living _____ Health Problems _____
 If deceased, age at death _____ cause: _____
 Number of brothers and sisters: _____ Health problems _____
Have your relatives had any of the following? Please circle.

Diabetes	CANCER (type)	Arthritis
Heart Trouble	Breast Cancer	Mental Illness
Heart Attack	Melanoma	Depression
High Blood Pressure	Skin Cancer	Suicide
Stroke	Thyroid disorder	OTHER: _____

BIRTH-PLACE _____ **OCCUPATION** _____

PRESENT WEIGHT _____ One year ago _____ **HEIGHT** _____ Goal weight _____
Number of Children _____ **Number of People in Household** _____

PLEASE CIRCLE and PRINT
Use of alcohol: NEVER QUIT DAILY Current amount / per week: _____
Use of tobacco: NEVER QUIT Type _____ Amount/ day _____
Use of drugs: NEVER QUIT Type/ frequency _____
Use of Caffeine: NEVER Less than 1-2 cups/ cans daily _____ More than 3 cup/ cans/ day _____
Exercise: NONE NO REGULAR REGIMIN YES _____ How often? _____
Diet habits: BALANCED MEALS _____ HIGH IN FAT _____ HIGH IN CARBOHYDRATES _____
 VEGETARIAN _____ Are you presently dieting? YES NO Type? _____
Use of seatbelts: YES NO Have you had any recent falls? YES NO Smoke Alarms? YES NO
Excessive exposure at home or work to: DUST FUMES NOISE SECOND HAND SMOKE
 SOLVENTS OTHER _____

Reviewed by: _____