

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**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**E. FINANCIAL / PRIVACY AGREEMENT**

**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**  
 -If patient does not have insurance at least 40% of fee is expected at the time of service.  
 - Payment in full at the time of visit is necessary for the discounted fee.  
 -All outside discounted lab fees and all products must be paid in full at the time of service.  
 -There will be a \$35.00 fee for any returned checks.  
 -The Bellingham Family Health Clinic reserves the right to change the terms/fees without notice.

**NO SHOW POLICY**  
 - A \$50.00 "No Show" fee will be charged for failing to show up on time for a scheduled appointment without cancelling at least 24 hour in advance. Additionally, future appointments cannot be scheduled until the "No Show" fee is paid.

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 <b>IMMUNIZATIONS</b> 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: \_\_\_\_\_