WhidbeyHealth
Primary Care

New Patient Form

Welcome!

We appreciate that you have chosen to entrust us with your healthcare needs. At WhidbeyHealth Primary Care, we are dedicated to serving our patients with the highest professional and ethical standards of care.

In order to maintain such standards, it is important that we get acquainted with you, and your medical history. To help with this process we have enclosed the new patient information Registration Form and Medical Record Release Form. Please complete and return these forms to our office.

For your first appointment please bring the following:

- Completed New Patient Forms (Available Online for printing)
- Your Insurance Card
- Your Photo ID or License – If the address on your license is different from your present address, please provide utility, water, or garbage bill for address verification
- Your Copay (if you have one)
- Patient Payment Responsibilities- co-pay indicated on your insurance card and co-insurance amount (usually 20% of charges)
- Any Prescription Medication you are currently taking
  (Or a complete list, including over-the-counter medications,
  Vitamins, and/or supplements)

The above information is ***vital*** to maintain your healthcare in a safe and informed manner.

Once again, we welcome you. If you have any questions or concerns, please feel free to contact our office.

Respectfully,

WhidbeyHealth Primary Care

WhidbeyHealth
Primary Care

WhidbeyHealth Primary Care
www.whidbeyhealth.org

PATIENT INFORMATION

Date________________________________

Patient Acct. #______________________

Mr./Ms ____ Home Phone ________________________________
Mrs./Miss Last First MI Work Phone ________________________________
Address ____ Employer ________________________________
City ____________________ State ________ Zip ____________ Would you like to be contacted via email for lab results, appts., etc. Y N
Social Security # ______________________________________ Email ________________________________
Birthdate ______________ Sex: M F Marital Status: Single Married Other
Language ______________ Employment/student status: Employed FULL PART
Primary Care Physician__________________________ Emergency Contact Person________________ ____
Allergies __________________________________ Phone Number____________________________
Current Medication __________________________

INFORMATION FOR PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE (GUARANTOR)

Mr. /Ms ____ Guarantor Home Phone ________________________
Mrs. /Miss Last First MI Guarantor Work Phone________________________
Address ____ Relation to Patient ________________________
City______________ State_____ Zip__________ Employer____________________________

IS THE PATIENT COVERED BY MEDICAL INSURANCE? YES NO

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE	OTHER INSURANCE
Insurance name			
Subscriber's name			
Subscriber's employer			
Subscriber's ID# or SS#			
Group, member #, or claim #			
	Subscriber's address if different from patient	**Subscriber's phone if different from patient**	**Subscriber's birthdate**

Are you of Hispanic or Latino origin or descent?
- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

What is your race? Please mark one or more.
- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or

Date: ____________ Signature: ____

11245 State Route 525, Clinton, WA 98236 • 360.341.5252
5486 Harbor Avenue, Freeland, WA 98249 • 360.331.5060
275 SE Cabot Drive, Suite B101, Oak Harbor, WA 98277 • 360.675.6648
1300 NE Goldie Street, Oak Harbor, WA 98277 • 360.679.5590

9451-013342-0816N

WhidbeyHealth
Primary Care

Patient Name____ **Date of Birth:** _________ **Age:** _____ **Date:** ____________

☐

Have you had any of the following health problems?

	Yes	No	What type?	When?
Hospitalized - Illness				
Hospitalized – Surgery				
Major Illness/Injury				
Childhood Illness				
Allergies				
Other Problems				

Has any blood relative had any of the following health problems?

	Yes	No	Who?	What type?
Allergy/Asthma				
Cancer				
Diabetes				
Heart Disease/Attack				
Hypertension/Stroke				
Seizure/Epilepsy				
Tuberculosis				
Mental Illness				
Alcoholism				
Other Chronic Illness				

MEDICATIONS

	Yes	No	Name?	Strength?	How often?
Prescription					
Non-prescription					
Alcohol use					
Tobacco					
Smokers in the home?					
Caffeine					
Other Drugs					
Exercise					
Are immunizations all current?			***Last tetanus shot:*** ________________________________ ***Please give the nurse your shot record, if available***		

For Women Only:

Deliveries ________ **Miscarries** ____________ **Abortions** _________

Pregnancies __________________

Birth Control: **None** **Condom** **Diaphragm** **IUD** **Tubal** **Norplant** **Vasectomy** **BCP**

Last PAP smear _____________________ **NL ABNL** Last Mammogram: ___________________ **NL ABNL**

WhidbeyHealth
Primary Care

WhidbeyHealth Primary Care
www.whidbeyhealth.org

REQUEST FOR MEDICAL RECORDS

Patient Name ____

Date of Birth ________________ SS# ______________________________

Release From: ____

(Past Providers,
Hospitals, etc.) ____

Release To:

____ WhidbeyHealth Primary Care: 275 SE Cabot Dr., Oak Harbor, WA. 98277 FAX: 360 679 2487

____ WhidbeyHealth Primary Care: 5486 S Harbor Ave. PO Box 462 Freeland, WA. 98249 FAX: 360 331 2104

____ WhidbeyHealth Primary Care: 11245 State Route 525, Clinton, WA. 98239 FAX: 360 341 8727

____ WhidbeyHealth Primary Care:1300 NE Goldie St. Oak Harbor, WA. 98277 Fax: 360 675 1440

____ Other__________________________________(Self, Other Providers, etc.)

Information to be Released: ___ Complete Medical Abstract (includes 2 years of chart notes, most recent labs/pathology diagnostic imaging).
___ Other: ________________________

I authorize the use or disclosure of the named individual's information as described above by the individual or organization listed above. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded here:
____.

I understand that I have a right to revoke this authorization at any, and I must do so in writing and present my revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire ninety days after the date the authorization is signed, or sooner, at my election on the following date, event, or condition: ____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact WhidbeyHealth, Health Information Services.

____ Date: ________________
Signature of Patient

____ Date: ________________
Legal Representative/Relationship to Patient

____ Date: ________________
Signature of Witness

WhidbeyHealth
Primary Care

WhidbeyHealth Primary Care
www.whidbeyhealth.org

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient at our clinic, you have the RIGHT to:

- Be treated and cared for with dignity and respect, including cultural and spiritual beliefs.
- Know the nature and purpose of any procedure or treatment provided here, and who will perform the procedure.
- Participate in your care including resolving problems, with family or surrogate decision makers if appropriate.
- Receive accurate information regarding your condition, medical care, treatment alternatives, risks and possible side-effects of specific treatments.
- Refuse treatment, within the restraints of the law and be informed of the consequences of actions.
- Personal and informational confidentiality and privacy with respect to all WhidbeyHealth personnel, doctors and other patients.
- Be asked permission to have a student involved in your visit, and have the choice to refuse.
- Have insurances billed if we accept them including DSHS, Medicare, and many other insurances.
- An explanation of your bill, and counseling to obtain financial assistance if needed.
- Treated in a safe and secure environment, protected from abuse and neglect.
- Timely complaint resolution. Register a complaint by contacting the clinic supervisor/manager.
- Informed about advance directives and end-of-life care.

As a patient at our clinic, you have the RESPONSIBILITY to:

- Provide truthful information regarding your medical history and follow the provider's advice to the best of your ability.
- Treat clinic staff and other patients with courtesy and respect. Situations that threaten the safety or the cordial atmosphere of the clinic may result in a 911 call or dismissal from the practice.
- Give the clinic **72 hours notice for prescription refills.** This includes sample medications and meds that require a written script. **Call refill requests** to your pharmacy, excluding prescriptions that must be hand written or sample meds.
- Ask your provider or nurse what to expect regarding pain management in the clinic.
- Inform staff of changes in your insurance coverage, your own address, and phone number.
- **Be prepared to pay the co-pay and co-insurance (usually 20% of charges) at the time of each visit**.
- Give notice as soon as possible if you are unable to keep a scheduled appointment. If you are late for an appointment, you will be rescheduled to another time.
- Schedule follow-up appointments. We cannot accommodate walk-in visits.

PRINT PATIENT'S NAME and Date of Birth:

WhidbeyHealth
Primary Care

WhidbeyHealth Primary Care
www.whidbeyhealth.org

Patient Name and Date of Birth:

CONSENT FOR TREATMENT

_____I hereby consent to clinic services as may be rendered to me by clinic staff. I understand that my case is under the direction of my primary healthcare practitioner and that my consent may be withdrawn at any time.

ASSIGNMENT OF BENEFITS

_____ I authorize and assign payment of government and medical insurance benefits for services provided me by WhidbeyHealth Primary Care staff to WhidbeyHealth Primary Care.

RELEASE OF MEDICAL INFORMATION TO SECURE PAYMENT

I authorize WhidbeyHealth Primary Care and WhidbeyHealth Medical Center to release all medical information necessary to secure the payment of benefits.

______I understand that I am entitled to confidential treatment of information relating to testing and/or treatment for sexually transmitted diseases, AIDS or HIV related diseases, mental health conditions, and alcoholism or drug abuse. You are hereby specifically authorized to release information relating to such testing, treatment or diagnosis necessary to secure the payment of benefits. This information is confidential and is released solely for the purpose of treatment and payment of benefits. You may not release this information to another entity or individual without my express consent or unless authorized by law. If I do not provide this authorization, I understand I will be responsible for any payment of services provided related to these confidential diagnoses.

PATIENT SIGNATURE: ____ **DATE:** ____________

PARENT OR GUARDIAN: ____ **DATE:** ____________

WITNESS: ____ **DATE:** ____________

IF A PATIENT HAS REACHED HIS/HER FOURTEENTH (14th) BIRTHDAY ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE AS NOTED BELOW:

AUTHORIZATION BY MINOR (AGE 14 - 17) TO RELEASE CONFIDENTIAL DIAGNOSIS FOR PAYMENT

I understand that I am entitled to confidential treatment of information relating to treatment for contraception, pregnancy, pregnancy termination, sterilization, sexually transmitted diseases, mental health conditions, and alcoholism or drug abuse. This information is confidential and is released solely for the purpose of treatment. You may not release this information to another entity or individual without my express consent or unless authorized by law.

PATIENT SIGNATURE: ____ **DATE:** _____________

WITNESS: ____ **DATE:** _____________

IF A PATIENT HAS REACHED HIS/HER THIRTEENTH (13th) BIRTHDAY, ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE AS NOTED BELOW:

AUTHORIZATION BY MINOR (AGE 13 – 17) TO RELEASE CONFIDENTIAL DIAGNOSIS FOR PAYMENT

I understand that I am entitled to confidential treatment of information relating to treatment of mental health conditions. This information is confidential and is released solely for the purpose of treatment. You may not release this information to another entity or individual without my express consent or unless authorized by law.

PATIENT SIGNATURE: ____ **DATE:** _____________

WITNESS: ____ **DATE:** _____________

11245 State Route 525, Clinton, WA 98236 • 360.341.5252
5486 Harbor Avenue, Freeland, WA 98249 • 360.331.5060
275 SE Cabot Drive, Suite B101, Oak Harbor, WA 98277 • 360.675.6648
1300 NE Goldie Street, Oak Harbor, WA 98277 • 360.679.5590