Pendleton Primary Care Clinic

Patient Registration Form

Date: _____

PATIENT INFORMATION

First Name: _____ **Middle:** _____ **Last Name:** _____

Date of Birth: _____ **Sex:** ☐ **Male** ☐ **Female** **Social Security #:** _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other: _____ ☐ Decline

Sexual Orientation: ☐ Straight/Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Other: _____ ☐ Decline

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Unknown ☐ Decline

Preferred Language: _____ **Ethnicity:** ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown ☐ Decline

Cell Phone: _____ **Other Phone:** _____ **Email:** _____

How would you prefer to be contacted? ☐ Text ☐ Phone ☐ Email

Mailing Address: _____

City: _____ **State:** _____ **Zip:**_____

Emergency Contact: _____ **Relationship to patient:** _____ **Phone #:** _____

Would you like to file a POLST (physician orders for life sustaining treatment) or an Advanced Directive with the Oregon Registry? ☐ Yes ☐ No

RESPONSIBLE PARTY *(IF DIFFERENT THAN ABOVE)*

First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Relationship to Patient: _____ **SSN:** _____ **Cell Phone:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Group #:** _____ **ID #:** _____

Subscriber Name: _____ **Relationship to Patient:** _____ **Subscriber DOB:** _____

Secondary Insurance Company: _____ **Group #:** _____ **ID #:** _____

Subscriber Name: _____ **Relationship to Patient:** _____ **Subscriber DOB:** _____

Preferred Pharmacy: ☐ Pendleton Walmart ☐ Pendleton Rite Aid ☐ Pendleton Safeway ☐ Other: _____

How did you hear about us? ☐ Friend ☐ Google Search ☐ Facebook ☐ Our Website ☐ Radio ☐ Newspaper ☐ Insurance Company ☐ Other Online Source: _____ ☐ Other: _____

Pendleton Primary Care Clinic

Medical Intake Form

Patient Name: _____ Date of Birth: _____ Today's Date: ___/___/___

Allergies/Intolerances ☐ No known allergies

Allergy	Allergic Reaction

Personal Medical History

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma/COPD			
Cancer (type:_____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:_____)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Kidney Disease			
Migraine Headaches			
Osteoporosis/Osteopenia			
Thyroid Disease			
Stroke			
Other: _____			
Other: _____			

Surgical History ☐ No previous surgeries

Surgery Type *(Specify Left/Right)*	Date	Location/Facility

Patient Name: _____ Date of Birth: _____

Family Medical History ☐ No significant family history is known

✓ Check All That Apply	Alcoholism/Drug Abuse	Cancer type:_____	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Lung Disease	Thyroid Disease	Kidney Disease	Migraines	Stroke	Other:_____
Mother														
Father														
Brother														
Sister														
Child														
MGM														
MGF														
PGM														
PGF														
Other: _____														

Other Health Issues

Tobacco Use	Smoke Cigarettes Y N Other: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape
Current: Packs/Day: ____ # of Years: ____ Past: Quit date: _____ Packs/day ____	
Alcohol/Drug Use	Do you drink alcohol Y N ☐ Beer ☐ Wine ☐ Liquor # of Drinks/week ___
Marijuana use ☐ Past ☐ Current Other recreational drugs ☐ Past ☐ Current	

Medications

Medications *(Please List All)*	Dose *(Mg., Pill, Etc)*	Times Per Day	Prescriber

Please list additional medications on a blank sheet of paper with the required information

Other Providers/Specialists

Provider	Name	Last Visit

Pendleton Primary Care Clinic

Treatment Authorization Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Consent To Treat

By signing below I am allowing Pendleton Primary Care Clinic LLC (PPCC) to provide health care related treatment and consultation to the previously-names patient and that I may refuse treatment or services at any time. I understand PPCC does not guarantee any outcome for any services or treatment whether stated or implied.

Assignment, Release and Authorize

I, assign directly to PPCC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the provider or clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that I have the right to review a written description of how PPCC will handle my health information. The written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of PPCC and my right regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of a revised Notice of Privacy Practices. I also understand that a copy of or summary of the most current version of PPCC's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

Patient Confidential Communication

The HIPPA gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following:

I give permission to PPCC to leave message regarding: Appointments____ Billing_____

Medical information, such as results, medication information, generic recommendations, or referral status or updates will be given to the patient only unless specified here:

Name: _____ Phone #: _____ Relation to Patient:_____

_____	_____	_____
Patient/Representative Name	*Signature*	*Date*

Pendleton Primary Care Clinic

1100 Southgate Ste 11
Pendleton, OR 97801
Phone: 541-966-6916 Fax: 541-228-9120

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

Phone: _____ Address: _____

I hereby authorize Pendleton Primary Care Clinic to (choose one):

- ☐ **use or share my protected health information as follows WITH:**
- ☐ **obtain my protected health information FROM:**

Name of Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Authorization for the release of information from _____ to _____:

- ☐ All Records
- ☐ Chart Notes
- ☐ Lab Results
- ☐ Hospital Records
- ☐ Radiology Reports
- ☐ Other/Comments: _____

I understand that after the custodian of records discloses my health information it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

_____ _____ _____

Patient/Representative Name *Signature* *Date*