

Hawks Prairie Family Medicine New Patient Information & Clinic Policies

WELCOME TO YOUR MEDICAL HOME: Thank you for choosing Hawks Prairie Family Medicine as your medical home. We appreciate the opportunity to provide you with exceptional team-based care. Our team looks forward to your involvement in your healthcare and to keeping you well.

MYCHART HEALTH RECORD IS OUR PRIMARY MODE OF COMMUNICATION: MyChart gives you online access to your health record. Whether you are at work, on the road, or at home, you may view test results, messages from your provider and team, access your medical record, and make and cancel your own appointments. Ask how to sign up today!

EXPERIENCE THE MEDICAL HOME DIFFERENCE: We view you as a key partner in your care. One of the advantages of a medical home is that you will have the opportunity to establish a continuous relationship with your personal care team, led by your primary care provider. We will coordinate your care so that you see the appropriate team member for your visit or specific needs.

TELL US HOW WE ARE DOING: We strive to provide the highest level of service. To help ensure you receive the best care possible, we encourage you to participate in decisions regarding your care and treatment plans. We periodically will send surveys following your appointment and rely on your responses to help us know where we are succeeding and where we have opportunities for improvement. We always welcome your feedback and if you have any questions, concerns, or comments, please let us know during your visit or give us a call at 360-413-4200.

CLINIC HOURS: Monday through Friday, 7:00 AM – 5:30 PM

SAME DAY APPOINTMENT REQUESTS: Our providers have appointment times reserved for same-day visit requests and we do our best to accommodate these requests. If your primary physician is not available, you may be offered an appointment with a different physician in our office for evaluation of an acute problem, or for certain conditions, with a registered nurse. Requests for these same day appointments should be made by phone.

MEDICAL QUESTIONS OR CONCERNS: If you need to speak to someone on your care team about a medical concern, please call us at 360-413-4200. If a team member is not immediately available at the time you call, please leave a message and we will return your call as promptly as possible. MyChart is also a valuable resource for you to reach your care team with questions or concerns. We ask that you do not drop-in to the clinic without an appointment as we are not equipped for emergent care.

AFTER HOURS: *If you have a medical emergency, please call 9-1-1.* If you have an urgent medical concern and need to reach the provider on-call after normal clinic hours, please call the clinic and follow the prompts. The on-call physician will call you back to discuss your concerns, and send your primary care physician the documentation of the call. Prescription refills, referral questions, or appointment requests are not considered an urgent medical concern and the provider on-call cannot address or assist with these requests.

IMMEDIATE CARE: In the event that you have an urgent medical concern that needs to be addressed before your primary care team can see you, you have the option of receiving care at our Immediate Care Clinics. This is a walk-in clinic and on busier days, patients may experience extended wait times. The providers at Immediate Care do not provide, refill, or prescribe controlled substance medications.

IMMEDIATE CARE HOURS: Monday through Friday, 8AM – 7:30PM; Saturday and Sunday, 9AM – 4:30PM

LACEY IMMEDIATE CARE Located at: 4800 College St SE, Lacey WA 98503 **Phone:** 360-486-2900

WEST OLYMPIA IMMEDIATE CARE Located at: 1620 Cooper Point Rd SW, Olympia WA 98502 **Phone:** 360-486-6710

HAWKS PRAIRIE IMMEDIATE CARE Located at: 2555 Marvin Rd. NE Lacey, WA 98516 **Phone:** 360-493-4450

FEES: Your co-payment is due at the time of service. There are a few exceptions, such as preventative exams, nurse visits, and injections. If you have no insurance coverage, payment is due at the time of service. We accept cash, check, money order, and most major credit cards. Providence does offer options for payment plans or financial assistance; please contact the business office at 866-747-2455 for more information or to make arrangements.

ANNUAL PHYSICALS AND WELLNESS EXAMS: Please check with your insurance company prior to the visit to see if this is a covered benefit. If you have a specific problem to be addressed the same day as your preventative exam, the physician may reschedule the treatment of that specific problem for another day.

MEDICATIONS: The medications prescribed for you are those that your primary care provider feels would most benefit your specific condition. If you need a prescription refill, call your pharmacy and ask them to fax us a refill request. You may also request a refill through MyChart. Please allow at least 72 business hours to process refills. Many insurance companies place certain limitations or requirements on medication coverage and we will strive to work within these parameters, but it is important for you to know your insurance company may not cover all medications prescribed.

REFERRALS: Many insurance companies require referrals for you to see specialists, have certain tests, or receive other forms of treatment. It is important that authorizations be in place prior to receiving the appropriate care. Most referrals take at least 72 business hours to process, but there are occasions where it can take longer. When we submit a referral, it does not always mean approval will be granted. Due to insurance coverage, we suggest you check directly with your insurance company so you understand your benefits. If you self-refer outside of Providence Health System please inform us so we can obtain the records from your visit.

YOUR MEDICAL RECORDS/FEES: Your right to privacy is very important, and your medical record is confidential. In order for us to release your medical records, you must sign a records release form, which are available at our office or on our website.

MISSED APPOINTMENTS/CANCELLATIONS: Because your health is important to us, we want to see you in a timely manner. Arriving on time for your scheduled appointment is greatly appreciated, but we understand that unanticipated circumstances can arise. If you need to cancel or reschedule your appointment, we kindly request that you give us 24 hours notice. Patients who miss multiple appointments without advanced notice may be asked to leave the practice. Arriving late for a scheduled appointment may result in being rescheduled.

TRANSFER OF CARE/RE-ESTABLISH CARE: If for any reason you transfer your care to a provider outside of Providence Medical Group please notify us so we can update your medical records. If for any reason you are not seen in our clinic for 3 years you will need to re-establish care as a new patient.

My signature acknowledges that I have read and understand the policies of my provider's office as stated above.

Patient Name, *please print*

Date of birth

Patient Signature

Date

ADULT MEDICAL HISTORY FORM (please circle answers/complete blanks) rev 11/2018

Name: _____

Date of Birth: _____ Today's Date: _____

Where did you get healthcare before? _____

May we request records? Y N (requires signed release)

Allergies: _____

Social History:

Occupation: _____

Who do you live with? _____

Status: Single Married Separated Divorced Widowed

Alcohol use: Never Quit Current use, # of drinks consumed per week _____ (type: _____)

Tobacco use:

Cigarettes/cigars/pipe/vape: Never Quit date: _____

Current use: _____ packs/day for _____ years

Chewing tobacco: Never Quit date: _____

Current use: _____ # of cans/week

Drug use: Never Quit date: _____

Past use of: _____

Current use: _____

Exercise: None Regular exercise _____ days per week. Type: _____

Sexually active: Yes/No/Not Currently Preferred Partner: Male/Female/Both

Birth control method? _____

Health Maintenance:

Please give approximate date and result (normal or abnormal) if applicable, write "NEVER" if never done

<u>Date / Result</u>	<u>Date / Result</u>
Physical Exam _____	Mammogram _____
Colonoscopy _____	Pap Smear _____
Tetanus booster _____	Bone Density (DXA) _____

Are there any other physicians involved in your care? (if so please list their names)

PHQ-2-In the last 2 weeks, have you been bothered by any of the following? (Circle one)

1. Little interest/pleasure in doing things? 0=Not at all 1=Several days 2=More than half the days 3=Nearly every day
2. Feeling down, depressed/hopeless? 0=Not at all 1=Several days 2=More than half the days 3=Nearly every day

PAST MEDICAL HISTORY (Please circle if you have or have had any of the following)

	Comment		Comment		Comment
Environmental Allergies		Depression		Heart Attack	
Anemia		Diabetes Mellitus		Nerve or Muscle Disease	
Anxiety		Emphysema		Osteoporosis	
Asthma		GERD		Seizures	
Blood transfusion		Glaucoma		Sickle Cell Anemia	
Cancer		Heart Murmur		Stroke	
Cataracts		HIV/ AIDS		Substance abuse	
Congestive heart failure		High cholesterol		Thyroid Disease	
Clotting disorder		High blood pressure		Tuberculosis	
COPD		Kidney disease		Ulcers	
		Meningitis			
Other (add):					

PAST SURGICAL HISTORY (Please circle if you have or have had any of the following)

	Date		Date		Date
Appendectomy		Colon surgery		Hernia repair	
Brain surgery		Cosmetic surgery		Hysterectomy	
Breast surgery/biopsy		C- section		Joint replacement	
Cardiac artery surgery		Ear surgery		Small intestine surg	
Angioplasty/stent		EGD (upper scope)		Spine surgery	
Pacemaker/defibrillator		Eye surgery		Tonsils/Adenoids	
Valve surgery		Sinus surgery		Tubal ligation	
Vascular(vein/artery)		Uvulectomy (UPPP)		Ovary surgery	
Gallbladder removal		Fracture Surgery			
Other (add):					

Gynecology History (FEMALE)

How Many Pregnancies	How Many Live births	Date of last period

Patient Name: _____ **Date of birth:** _____

PROVIDENCE MEDICAL GROUP - HAWKS PRAIRIE FAMILY MEDICINE

Please complete accurately. Please also bring in your medications to your first visit in case your provider needs to see the prescription bottles.

<u>Medications</u>	<u>Dosage</u>	<u>Frequency</u>

Medication Allergies

Preferred Pharmacy name and Address: _____

Patient Name: _____ **Date of birth:** _____

PROVIDENCE MEDICAL GROUP - HAWKS PRAIRIE FAMILY MEDICINE

REVIEW OF SYSTEMS

*****Circle the items in each category that presently cause you problems or discomfort*****

General

Recent Weight Change
Fever/chills
Night sweats
Fatigue
Malaise/feeling ill

Allergic/Immunologic

Sneezing/runny nose
Itchy/irritated eyes
Nasal/sinus congestion
Frequent colds/illness
Recurrent pneumonia
Recurrent sinus infections

Integumentary (skin/breast)

Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast Pain
Breast Lump
Breast discharge
Skin ulcer
Skin change/growth/lesion
Skin infection

Eyes

Eye pain
Eye redness
Eye discharge
Vision changes
Blurred/double vision

Ears/Nose/Throat/Mouth

Hearing Loss or ringing
Earaches or drainage
Sinus problems
Nose bleeds
Sinus/face pain
Bad Breath or bad taste
Sore throat or voice change
Swollen glands in neck

Respiratory

Cough
Coughing/spitting blood
Shortness of breath
Wheezing
Snoring

Cardiovascular

Chest pain
Palpitation/irregular heartbeat
Rapid heartbeat
Shortness of breath
Swelling of feet, ankles or hands

Gastrointestinal

Loss of appetite
Nausea or vomiting
Heartburn/reflux
Abdominal pain
Diarrhea
Constipation
Change in bowel movements
Rectal bleeding/blood in stool
Rectal/anal pain
Bowel incontinence

Genitourinary

Frequent/urgent urination
Burning/painful urination
Blood in urine
Difficulty with urination
Incontinence/dribbling
Sexual difficulty
Painful periods
Heavy periods
Irregular periods
Vaginal discharge
Urethral discharge

Musculoskeletal

Joint Stiffness
Joint pain
Joint Swelling
Muscle weakness

Muscle pain/cramps

Limb pain/injury
Back pain/injury
Neck pain/injury
Cold extremities
Difficulty walking

Neurological

Headaches
Concussion
Light headed/dizzy
Fainting/collapse
Seizures
Numbness/tingling
Weakness
Tremors
Paralysis
Head Injury

Endocrine

Glandular/hormone problem
Hot flashes/night sweats
Excessive thirst/urination
Heat or cold intolerance
Dry skin
Skin/nail changes
Change in hat or glove size

Hematological/Lymphatic

Slow to heal after cuts
Easy bleeding or bruising
Vein problems
Swollen glands

Psychiatric

Sadness/Grief
Depression
Panic/Anxiety
Stress
Hallucinations
Sleep problems
Substance abuse
Alcohol abuse
Suicidal thoughts

Patient Name:

Date of birth:

Patient Signature:

Today's Date:

Please fill in your family history with a check mark for anything that applies. Thank you!

Relationship	Alive/Deceased	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Early Death	Hearing Loss	Heart Disease	Hypertension	High Cholesterol	Kidney Disease	Learning Disability	Mental Illness	Mental Retardation	Miscarriages	Stroke	Substance Abuse	Vision Loss	Other
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
M. Aunt																						
M. Uncle																						
P. Aunt																						
P. Uncle																						
MGM																						
MGF																						
PGM																						
PGF																						
Other																						

MGM= Maternal Grandmother

MGF= Maternal Grandfather

PGM= Paternal Grandmother

PGF= Paternal Grandfather