

## **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 – 730PM; Saturday and Sunday, 9AM – 430PM

**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



**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

## Pediatric Medical History rev 2/2014

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Who child lives with (names) \_\_\_\_\_

### Birth History

1. Birthplace \_\_\_\_\_
2. Was pregnancy normal? \_\_\_\_\_
3. How many weeks? \_\_\_\_\_
4. Type of Delivery? \_\_\_\_\_
4. Was delivery normal? \_\_\_\_\_
5. Was baby full term? (weeks) \_\_\_\_\_
6. Birth Weight: \_\_\_\_\_
7. Birth Length: \_\_\_\_\_
8. Any nursery problems? \_\_\_\_\_
9. Pregnancy Problems? \_\_\_\_\_

### Hospitalizations

When, Where, Why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Past Medical History

1. Any problems with:
  - Sleeping \_\_\_\_\_ Bedwetting \_\_\_\_\_
  - Weight/Height \_\_\_\_\_ Nail biting \_\_\_\_\_
  - Nightmares \_\_\_\_\_ Hearing problems \_\_\_\_\_
2. Eating Habits: \_\_\_\_\_
- Nursed or Bottle-fed? \_\_\_\_\_
- Use special diets? \_\_\_\_\_
- Taking vitamins? \_\_\_\_\_
- Taking fluoride? \_\_\_\_\_
- Taking any medications? \_\_\_\_\_
3. Contagious Diseases (what age?)
  - Measles: \_\_\_\_\_
  - Mumps: \_\_\_\_\_
  - Rubella (German Measles): \_\_\_\_\_
  - Chickenpox: \_\_\_\_\_
  - Scarlet Fever: \_\_\_\_\_
  - Any other: \_\_\_\_\_
  - Travel to a foreign country: \_\_\_\_\_
  - Tuberculosis exposure: \_\_\_\_\_

### Surgery

Check and date all that apply:

Adenoidectomy \_\_\_\_\_ Ear tubes \_\_\_\_\_  
 Appendectomy \_\_\_\_\_ Gastrectomy \_\_\_\_\_  
 Circumcision \_\_\_\_\_ Heart Surgery \_\_\_\_\_  
 Cleft Lip \_\_\_\_\_ Inguinal Hernia \_\_\_\_\_  
 Cleft Palate \_\_\_\_\_ Lymph node Biopsy \_\_\_\_\_  
 Ear Tubes \_\_\_\_\_ Other: \_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History

Check the following that apply:

Heart murmur: \_\_\_\_\_ ADD/ADHD \_\_\_\_\_ Environmental allergies \_\_\_\_\_ Asthma \_\_\_\_\_ Cancer \_\_\_\_\_  
 Chronic Encephalopathy \_\_\_\_\_ Diabetes mellitus \_\_\_\_\_ Eczema \_\_\_\_\_ Headaches \_\_\_\_\_ Hearing Loss \_\_\_\_\_  
 Seizures \_\_\_\_\_ Strep throat \_\_\_\_\_ Varicella \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ Inflammatory bowel disease \_\_\_\_\_  
 Jaundice \_\_\_\_\_ Lead poisoning \_\_\_\_\_ Meningitis \_\_\_\_\_ Obesity \_\_\_\_\_ Otitis media \_\_\_\_\_ Pneumonia \_\_\_\_\_  
 Scoliosis \_\_\_\_\_ Sickle cell anemia \_\_\_\_\_ UTI \_\_\_\_\_ Vision problems \_\_\_\_\_ Other \_\_\_\_\_

Concerns that you would like to discuss? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other specialty physicians your child visits or needs a referral? \_\_\_\_\_

**Please bring a current copy of your child's immunizations to the visit**



# 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