GREENLAKE PRIMARY CARE PATIENT INFORMATION

Patient's Name_____
First Initial Last

Name you like to be called_____ Referred by_____

Gender: M F Social Security #_____-_____-_____ Birth Date_____
(Mo/Day/Yr)

Address _____
Street/ P.O. Box (Apt #) City State Zip Code

Billing Address (if different)_____
Street/ P.O Box (Apt #) City State Zip Code

Home Phone ( )_____Cell #( )_____

Employer_____

Occupation_____ Work Phone (_____)_____

Permission to leave messages on which phone number, if any?_____

Email address:_____

Family Status: Single Married Partnered Widowed Separated Divorced

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____
(Relationship to patient)

Address_____
City State Zip

Home Phone # (____)_____Work # (____)_____Other # (_____)_____
(cell, pager, message)

Med Power of Attorney _____Phone #_____

With whom may we discuss your care? _____

_____

BILLING INFORMATION

Who is responsible for the bill? Self Partner/Spouse POA Parent Other

Name, Address & Phone # (if different than above) _____

_____ (____) _____

INSURANCE INFORMATION

Primary insurance_____ Preferred Plan (PPO): Yes No
(Please provide card to receptionist for a photo copy)

Name of Subscriber (Who has the insurance?): _____

Soc. Sec # _____ Date of Birth _____ Co-pay: Yes No

Individual ID #:_____ Group # and/or Name:_____

Secondary insurance _____ Preferred Plan (PPO): Yes No
(Please provide card to receptionist for a photo copy)

Name of Subscriber (Who has the insurance?): _____

Soc. Sec # _____ Date of Birth _____ Co-pay: Yes No

Individual ID #:_____ Group # and/or Name:_____

Photo copies of insurance cards go here

Consent for Care: I give permission and authorize the providers and staff of Greenlake Primary Care to examine and treat me.

Insurance Release of Benefits and Information: I authorize insurance benefits to be paid directly to the provider or clinic. I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my insurance plan. I authorize the providers or insurance company to release any information required for processing of insurance claims. This authorization is in effect until rescinded in writing.

Date: _____ Signature of Patient/Guardian: _____

Greenlake Primary Care Financial Policy

Greenlake Primary Care participates with a wide variety of insurance plans including: Aetna, Cigna, First Choice, Labor & Industry, Medicare, Molina (**for children only**), Premera, Regence, Tri Care, Uniform, United Healthcare, and others.

Know your insurance plan. Before your visit, or if you change insurance companies, call the toll free number on the back of your insurance card.
Ask your insurance representative if the practitioner you wish to see is a provider covered on your plan. Then please designate us as your primary provider, if necessary.
You may also ask whether you need a written referral to specialists, how often this needs to be renewed, and your coverage and benefit limits.
Then:

- Bring your insurance cards to every visit.
- Tell us if your insurance has changed.
- Pay your co-pay at the time of your visit.

Greenlake Primary Care will submit your bill to your insurance company for you.

If you do not have medical insurance, it is your responsibility to make full payment at the time of your visit for the services given. If there is financial hardship, please tell us.

Please note:

- For your convenience we accept both Visa and Master Card.
- Checks returned for insufficient funds will result in an immediate charge of $35.00 against your account.
- There may be a minimum charge of $50.00 for not canceling your appointment 24 hours in advance.
- If payment at the time of service is a hardship, a special payment plan can be arranged. These plans generally do not span more then three months.
- Questions about your account can be answered by Jonathan at our billing office (206-528-2663).

Financial Responsibility, Release of Insurance Benefits, Release of Health Information to Insurer:
I authorize Greenlake Primary Care to request and directly collect, on my behalf, all public and private insurance coverage benefits due for products and services provided by Greenlake Primary Care.
I authorize Greenlake Primary Care, to release any health care information necessary to facilitate the processing of claims and audit of payments, for the services provided to me or my child by Greenlake Primary Care. The authorization is in effect until rescinded in writing.
If insurance benefits are paid directly to me, I will endorse these checks for such payments to Greenlake Primary Care.
I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my insurance plan.

I have read and understand this policy. A copy will be kept in my chart and a copy may be furnished to me at my request.

Print patient name _____ Date of Birth_____

Signed: _____ Date:_____

(Last update 11/1/2012)

Greenlake Primary Care

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so, unless the law authorizes or compels us to do so, or for the coordination of your care with another healthcare provider.

You may see your record and/or get information about it by contacting your practitioner.

You may ask for a copy of the record. There may be a record-copying charge, unless you are asking that records be sent to another practitioner. You may also ask to correct your record.

Our Notice of Privacy Practices describes in more detail how your health care record may be used and disclosed, and how you can access your information. Copies are available at our office or on our website: www.greenlakeprimarycare.com.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices. This signed acknowledgement form of my review will be retained in my medical record, in accordance with HIPAA Privacy Act regulations.

Patient Name_____ Date of Birth_____

_____

Signature of Patient/Guardian/ Legal Surrogate for Health care Date

_____ Printed

name of signer Relationship (parent, legal guardian, personal representative)

Pediatric Patients only: I hereby give my permission to Greenlake Primary Care to display on their bulletin board any pictures of my children that I supply to the clinic. Yes No

Signature_____ Date_____

(Parent, legal guardian, personal representative)

(Last update 7/1/2011)

PATIENT NAME_____ DATE_____

MAJOR HEALTH CONCERNS:

1.
2.
3.

Please list surgeries, hospital stays, injuries or fractures. Continue on back if needed.

DATE – ILLNESS or OPERATION-WHAT HOSP.

List all current meds. Include BCPs, shots, herbs, vits, skin & eye meds. Continue on back if needed.

MEDICATION - DOSAGE - REASON

ALLERGIES Please circle if you are allergic to: _____

Penicillin, sulfa, other Abx
Codeine, morphine or narcotics
Novacaine or other anesthetics
Iodine, tape, eggs, Immunizations
Other allergies & med intolerances

Do you smoke?_____ How much?_____
Age you began _____Age(s) you quit_____
How much alcohol per day, per week_____
How much coffee or caffeine_____
Recreational Drugs ?_____ Special diet?_____
What exercise? _____
Occupation? _____
Foreign travel? _____

FAMILY HISTORY Please list parents, brothers, sisters, children

Relative	Yr. born	Health problems. Cause and date of death
Mother		
Father		

Any relatives with:

Hypertension
Heart Disease
Diabetes
Cancer
breast, colon
Mental illness
Alcoholism

REVIEW OF SYSTEMS: Circle any problems. Mark (C) if current. Mark (X) if past, and your age then

_____Eye or vision problems, glaucoma
_____Ear pain, infections, hearing problems
_____Hay fever, sinusitis, sore throat
_____Teeth or gum problems, dentures
_____Chest pain, heart palpitations, murmur
_____Short of breath, esp. lying flat or walking
_____Ankle swelling, fluid retention
_____Cough, wheezing, asthma, TB exposure
_____Problems with appetite, swallowing, gas
_____Heartburn, abdominal pain, hemorrhoids
_____Digestion, diarrhea, constipation, black stools
_____Jaundice, hepatitis, gallstones, ulcers
_____Bladder infections, kidney stones
_____Urinary incontinence or retention
_____Thyroid or blood sugar problems
_____Anemia, phlebitis of legs, transfusion
_____Skin rashes, itching, hives, warts, moles
_____Back aches, joint pains, headaches
_____Tremor, seizures, dizziness, fainting
_____Difficulty walking, weakness

_____Insomnia, sleepiness
_____Fatigue, fevers, night sweats
_____Weight loss, weight gain
_____Change in home, job, family in past year or illness or death of family or friends
_____Depression, or mental disorders
_____Drug or alcohol abuse, eating disorder
_____Stress. Anxiety, panic
_____Practicing safe sex; sexual problems
_____Orientation: Hetero, Gay, Lesbian, BI
_____Gonorrhea, Chlamydia, Herpes, Warts

FOR WOMEN ONLY

_____Breast tenderness, lumps, discharge
_____Periods irregular, heavy, painful
_____Used birth control pills, diaphragm, IUD
_____Abnormal Pap(s), vaginal discharge, odor
_____Hot flashes Age at menopause_____
Periods start every _____days
Days of flow _____ Age of onset_____
Number of Pregnancies.____ Miscarriages._____ Births_____