Bellingham Family Health Clinic, 302 36th St., Bellingham, WA, 98225. 360-756-9793 Fx: 360-752-9007

Please print A. PATIENT INFORMATION (We send the bill and medical information here)

Last Name_____ First Name_____ MI_____ Male____ Female____ Age_____

Home Address_____ City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____ Cell Phone Number_____

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____ Married____ Single____ Other_____

E-mail Address_____ School Name_____

Employer_____ Employer Address_____

Name of Person paying This Bill_____ _____ Self_____ Parent_____ Other_____

B. PARENT OR GUARDIAN INFORMATION (College Students list your Parents Address below)

Last Name_____ First Name_____ MI_____ Male____ Female____ Age_____

Home Address_____ City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____ Cell Phone Number_____

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____ Married____ Single____ Other_____

Employer_____ Employer Address_____

Name of Person paying This Bill_____ _____ Self_____ Parent_____ Other_____

C. INSURANCE INFORMATION (Please present copy)

Primary Insurance Company_____ Group Number_____ ID Number_____

Policy Holder Self_____ Parent/ Guardian_____ If Other Than Self_____
Last Name First Name Date of Birth

Secondary Insurance Company_____ Group Number_____ ID Number_____

D. EMERGENCY CONTACT INFORMATION

Last Name_____ First Name_____ Phone Number_____ Relationship_____

Address_____ City_____ State_____ Zip_____

E. FINANCIAL / PRIVACY AGREEMENT

PAYMENT OF BENEFITS

Bellingham Family Health Clinic will bill the patient's insurance provided the necessary information is supplied (ID/insurance card). By signing below, the patient (or parent/guardian):

-Authorizes payment from their insurance company directly to Bellingham Family Health Clinic.
-Agrees that after sixty (60) days all unpaid balances become their responsibility.
-Agrees that charges not covered by their insurance become their responsibility.

MEDICAL RELEASE AUTHORIZATION

-The insured party or dependent patient (if not minor) must sign on all claims.

Signing authorizes your insurance company, employer, hospitals, the clinic's billing/ collection agency, or health care provider to release any necessary information requested.

I certify that the information I furnish is true and correct, and that I have read, understand and agree to the policies and terms outlined above. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

TERMS

-If patient does not have insurance 100% of fee is expected at the time of service.
-All copayments are due at the time of service.
-All products must be paid in full at the time of service.
-There will be a $50.00 fee for any returned checks.
-The Bellingham Family Health Clinic reserves the right to change the terms/fees without notice.

NO SHOW POLICY

- We request a minimum of 24 hours notice for cancellation or rescheduling of appointments. You may be assessed a $50.00 "NO SHOW" fee. Repeated No Shows may result in your dismissal from the practice.

SIGNITURE _____

PRINTED NAME _____ DATE _____/_____/____

I have read or been given a copy of the PRIVACY POLICY. I understand and accept it. Yes_____No_____

BELLINGHAM FAMILY HEALTH CLINIC
302 36TH ST.
BELLINGHAM, WA 98225

NAME_____
DATE OF BIRTH_____
TODAY'S DATE_____

HEALTH HISTORY QUESTIONAIR (A copy of this form will be kept in your medical record)

Reason for today's visit?
_____
_____

What are your past/ current medical problems?
_____
_____
_____
_____
_____
_____

Operations/ and Hospitalizations? (Year/ reason)
_____
_____

Do you have any ALLERGIES to medications Y N
(list)
_____
_____

Other allergies:_____

Daily Medications or Supplements:
_____
_____
_____
_____
_____

How did you hear about this practice?
_____

1. PLEASE LIST DATES

COLONOSCOPY_____
CHEST X-RAY_____
EKG_____
LAST PHYSICAL EXAM_____
Last eye exam_____
MAMMOGRAM_____
(any abnormal) Yes No
PAP SMEAR_____
(any abnormal) Yes No

IMMUNIZATIONS

TETNUS_____
PNEUMONIA_____
HPV_____
HEPATITIS A_____
HEPATITIS B_____
TUBERCULOSIS_____

2. WOMEN (CIRCLE)

DATE OF LAST MENSTRUAL PERIOD
_____
# of pregnancies_____
# of births_____

DO YOU HAVE CONCERNS ABOUT:
Family planning
Irregular periods
Painful periods
Menopausal symptoms
Hot flashes
Bleeding between periods
Painful intercourse
Nipple discharge
Vaginal discharge
Other:_____

3. CURRENT SYMPTOMS (PLEASE CIRCLE)

GENERAL
Change to weight
Appetite
Sensitive to heat or cold
Sexual concerns
Fatigue

HEART
Chest pain or tightness
Palpitations
Swelling of ankles

RESPIRATORY
Cough. Wheezing. Shortness of breath. Hoarseness

EARS, NOSE, and THROAT
Hearing problems. Vision problems. Teeth or Gums.
Hay fever or sinus problems

GASTROINTESTINAL
Stomach pain. Heartburn.
Nausea or vomiting. Diarrhea.
Constipation. Blood in Stool

URINARY
Pain or burning.
Frequent urination.
Incontinence.

MOODS and OTHER
Headaches, Insomnia.
Anxiety. Depression.
Panic attacks.
Acne. Skin rashes.
Changing moles.
Back pain
Arthritis. Body aches.
Other:_____

FAMILY HISTORY

Mother: Age if living_____ Health Problems_____
If deceased, age at death_____ cause:_____
Father: Age if living_____Health Problems_____
If deceased, age at death _____cause:_____
Number of brothers and sisters:_____ Health problems_____
Have your relatives had any of the following? Please circle.

Diabetes
Heart Trouble
Heart Attack
High Blood Pressure
Stroke

CANCER (type)
Breast Cancer
Melanoma
Skin Cancer
Thyroid disorder

Arthritis
Mental Illness
Depression
Suicide
OTHER:_____

BIRTH-PLACE_____**OCCUPATION**_____

PRESENT WEIGHT_____One year ago_____ HEIGHT_____Goal weight_____
Number of Children_____**Number of People in Household**_____
PLEASE CIRCLE and PRINT
Use of alcohol: NEVER QUIT DAILY Current amount / per week:_____
Use of tobacco: NEVER QUIT Type_____ Amount/ day_____
Use of drugs: NEVER QUIT Type/ frequency_____
Use of Caffeine: NEVER Less than 1-2 cups/ cans daily_____ More than 3 cup/ cans/ day_____
Exercise: NONE NO REGULAR REGIMIN YES_____ How often?_____
Diet habits: BALANCED MEALS_____HIGH IN FAT_____HIGH IN CARBOHYDRATES_____
VEGETARIAN_____Are you presently dieting? YES NO Type?_____
Use of seatbelts: YES NO Have you had any recent falls? YES NO Smoke Alarms ? YES NO
Excessive exposure at home or work to: DUST FUMES NOISE SECOND HAND SMOKE
SOLVENTS OTHER_____

Reviewed by:_____