WHITESALMON
FAMILY PRACTICE CLINIC

181 West Jewett Blvd.
White Salmon, WA 98672
p. 509.493.1470

REGISTRATION INFORMATION

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PERSONAL INFORMATION		
Last Name:	**First Name:**	**MI:**
DOB:	**Gender:** ☐ Male ☐ Female	
Mailing Address:		
Email Address:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Preferred Number: ☐ Home ☐ Cell ☐ Work		
Emergency Contact Name:	**Emergency Phone #:**	

RESPONSIBLE PARTY (for patients who are minors) INFORMATION	
Name:	**Phone:**
Address (if different from above):	

INSURANCE INFORMATION	
Are you the "Primary Insured"? ☐ YES ☐ NO	
If "NO" – please list the name of the primary insured:	**DOB:**
☐ **I do not have insurance**	

ONE QUESTION SURVEY

We are very glad that you have chosen White Salmon Family Practice for your heath care needs. Please kindly tell us how you heard about us by checking all the items that apply:

☐ Family
☐ Friend(s)
☐ Newspaper Ad
☐ Phone Book
☐ Your Insurance Website
☐ Chamber of Commerce
☐ Referred by Medical Provider / Pharmacy
☐ Driven by the Office
☐ Other _____

WHITESALMON
FAMILY PRACTICE CLINIC

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*			
☐ **M** ☐ **F**	**DOB:**	**HEIGHT:**	**WEIGHT:**
Previous or referring provider:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY				
Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	
List any medical problems that other doctors have diagnosed				
Surgeries				
Year	Reason		Hospital	
Other hospitalizations				
Year	Reason		Hospital	

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

PHARMACY / RX INFORMATION
Preferred Pharmacy:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

PLEASE SHARE THE REASON FOR YOUR VISIT TODAY AND ANY OTHER CONCERNS YOU MAY HAVE.

WHITESALMON
FAMILY PRACTICE CLINIC

181 West Jewett Blvd.
White Salmon, WA 98672
p. 509.493.1470

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to White Salmon Family Practice or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that White Salmon Family Practice is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to White Salmon Family Practice or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the White Salmon Family Practice Patient Information Privacy Policy. I hereby authorize White Salmon Family Practice or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

LAB / X-RAY / DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing and treatment as directed by my White Salmon Family Practice health care provider.

PATIENT SIGNATURE: _____ DATE: _____

WHITESALMON
FAMILY PRACTICE CLINIC

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____	_____	_____
(patient name)	(patient signature)	(date)