Columbia Family Clinic

1012 S 3rd St Dayton, WA 99328 · (509) 382-3200

Waitsburg Clinic

235 Main St Waitsburg, WA 99361 · (509) 337-6311

Thank you for contacting the Columbia Family and Waitsburg Clinic regarding your healthcare. To better serve you and allow more time during your visit, these forms need to be filled out **before** scheduling your appointment.

Please also bring the following with you to your appointment:

- Photo ID
- Insurance Card and/or Medicare/Medicaid Card
- List of current medication and/or bring medications with you
- Co-payment

Your medical information is strictly confidential.

We look forward to working with you to meet your health goals.

Sincerely,

Columbia Family and Waitsburg Clinics

Columbia Family and Waitsburg Clinic
New Patient Packet

Legal Name: _____
Date of Birth: _____
Social Security No: _____
Preferred Name / Nickname: _____
Birth Gender: ☐ **Male** ☐ **Female**
Gender Preference: _____
Pronouns: _____

Physical Address: _____
City / State / ZIP: _____
Mailing Address (if different): _____
City / State / ZIP: _____

Primary Phone: _____ ☐ Cell ☐ Home
Secondary Phone: _____ ☐ Cell ☐ Home
Email Address: _____

Emergency Contacts

Emergency Contact 1

Name: _____

Relationship: _____

Phone Number: _____ ☐ Cell ☐ Home

Emergency Contact 2

Name: _____

Relationship: _____

Phone Number: _____ ☐ Cell ☐ Home

Marital Status:

☐ Single ☐ Married ☐ Domestic Partnership ☐ Widowed ☐ Other: _____

Join our Data Network Exchange Program? Yes ☐ No ☐

(Allows us to securely access your medical records from outside specialists.)

Race / Ethnicity (optional)

Race (select one or more):

☐ Asian
☐ Black / African American
☐ Native Hawaiian / Pacific Islander
☐ White / Caucasian
☐ Other: _____
☐ Decline to answer

Ethnicity (select one):

☐ Hispanic / Latino
☐ Not Hispanic / Latino
☐ Decline to answer

Work Information

Occupation / Employer: _____
Self-employed/Retired: _____
Work Phone: _____
Work Address: _____

Insurance Information

Primary Insurance: _____

- Subscriber Name: _____
- Subscriber Date of Birth: _____
- Plan / ID #: _____
- Group #: _____
- Relationship to Patient: _____

Secondary Insurance (if applicable): _____

- Subscriber Name: _____
- Subscriber Date of Birth: _____
- Plan / ID #: _____
- Group #: _____
- Relationship to Patient: _____

New Patient Medical History Form

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1. General Medical History (Circle if applicable)

- Asthma / COPD
- High blood pressure / High cholesterol
- Diabetes (Type 1 / Type 2)
- Heart disease / Heart attack / A-fib
- Liver disease / Hepatitis / Cirrhosis
- Blood disorders / Anemia / Blood clot
- Depression / Anxiety
- Surgeries: _____
- Allergies (medications / foods): _____
- Stroke
- Seizures / Epilepsy
- Cancer (Type: _____)
- Kidney disease
- Thyroid problems
- Autoimmune disease
- Other mental health conditions
- Hospitalizations

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2. Current Medications

Please list **all current prescription and over-the-counter medications, vitamins, and supplements** you are taking.

Preferred Pharmacy Name:_____

Medication Name	**Dosage**	**Frequency**	**Reason / Condition**
_____	_____	_____	_____
_____	_____	_____	_____

Columbia County HEALTH SYSTEM

Medication Name	Dosage	Frequency	Reason / Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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3. Lifestyle

- **Do you smoke?** ☐ Yes ☐ No
  If yes, how many per day? _____
  Previous smoking history: _____
- **Do you use smokeless tobacco (chew, snuff, etc.)?** ☐ Yes ☐ No
- **Do you drink alcohol?** ☐ Yes ☐ No
  If yes, how often? _____
- **Do you use recreational drugs?** ☐ Yes ☐ No
- **Exercise routine:** _____
- **Diet/Nutrition notes:** _____
- **Occupation (current or prior):** _____
  ☐ Retired ☐ Disabled

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4. Family Medical History

Check if any first-degree relatives have had:

☐ Heart Disease
☐ Stroke
☐ Diabetes
☐ Cancer (Type: _____)
☐ Genetic Disorders
☐ Mental Illness

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5. Women's Health (if applicable)

- **Age of first period:** _____
- **Date of last menstrual period (LMP):** _____
- **Menstrual cycles:** ☐ Regular ☐ Irregular
- **Bleeding:** ☐ Light ☐ Moderate ☐ Heavy
- **Do you experience:** ☐ Painful periods ☐ PMS symptoms
- **Are you currently pregnant?** ☐ Yes ☐ No
- **Number of pregnancies:** _____
    - **Live births:** _____
    - **Miscarriages:** _____
    - **Abortions:** _____
- **Have you experienced menopause?** ☐ Yes (Age: _____) ☐ No
- **Have you used hormone replacement therapy?** ☐ Yes ☐ No
- **Birth control method:** _____
- **Last Pap smear:** _____
- **Last mammogram:** _____

Any history of:
☐ PCOS
☐ Endometriosis
☐ Fibroids
☐ Breast lumps or cancer
☐ STIs
☐ Hysterectomy
☐ Other reproductive issues

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6. Men's Health (if applicable)

Any history of:
☐ Erectile dysfunction
☐ Low testosterone / Testosterone use
☐ Prostate issues (e.g., BPH, prostatitis)
☐ Testicular pain or masses
☐ STIs
☐ Other reproductive issues: _____

- **Last prostate exam:** _____
- **Last testicular exam:** _____

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7. Sexual Health (All Patients)

- **Are you sexually active?** ☐ Yes ☐ No
- **Partners:** ☐ Male ☐ Female ☐ Both ☐ Other: _____
- **Do you use protection?** ☐ Yes ☐ No

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8. Health Maintenance / Screening Tests

Please list **all recent health maintenance or screening tests**, including lab results, dates, or notes.

Test Name	Date Performed	Result / Notes
Lipids / Cholesterol	_____	_____
PSA / Prostate CA	_____	_____
Colon Cancer Screening	_____	_____
Mammogram	_____	_____
Bone Density	_____	_____
_____	_____	_____

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9. Vaccinations

Please list **all recent vaccinations**, including dates and any notes.

Vaccine	Date Received	Notes / Reactions
Influenza (Flu)	_____	_____
Tetanus	_____	_____
Pneumonia	_____	_____
Shingles	_____	_____
_____	_____	_____

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10. Other Providers / Specialists

Please list **any other healthcare providers or specialists you see**, including contact info.

Specialty	Specialist / Provider	Contact / Clinic Name
Cardiology	_____	_____
OB/GYN	_____	_____
Pulmonary	_____	_____
Other	_____	_____

Columbia County HEALTH SYSTEM

Columbia County HEALTH SYSTEM

APPOINTMENT SCHEDULING AND NO-SHOW POLICY

We will try our best to schedule your appointment at the most convenient time possible. We are open on weekdays beginning at 8 am, except Wednesdays when the clinic opens at 9 am, and every 2nd and 4th Saturday from 10 to 2.

When you are unable to keep a scheduled appointment, please call our office prior to your appointment so we may care for someone else during that time. Cancellations must be received 24 hours in advance.

If less than a 24 hour cancellation notice is given this will be documented as a "**No Show**" appointment; frequent late notice and/or "No Show" appointments (***3 or more within 6 Months***) can result in **dismissal from the practice.** Please be courteous to others who are waiting for appointments.

AFTER HOURS MEDICAL CARE

If you are needing to speak with a nurse or physician after hours, please call the office and you will be routed to the after-hours answering service. This service is available outside of our normal hours of operation, holidays, and office closings. The answering service is responsible for paging the physician or provider on call if needed. Please be aware that prescription refills or new prescriptions **are not** completed after hours.

PRESCRIPTION REFILLS

Please allow 48-72 clinic hours for prescription refills. Please make sure you monitor your medications and ask for refills in a timely manner.

I have read the above policies of Columbia Family Clinic

Name: _____ Date: _____

Columbia Family Clinic
1012 S 3rd St Dayton, WA 99328 · (509) 382-3200
Waitsburg Clinic
235 Main St Waitsburg, WA 99361 · (509) 337-6311

Columbia County Health System is allowed to give verbal/written medical information or updates about your condition to your Power of Attorney or Healthcare/Legal Representatives as listed in your medical records.
If you wish others, such as relatives or friends, **WHO ASK** about your condition, the right to be verbally informed about your condition when they inquire, please list the names of these individuals on the lines below.
I _____ as a patient of CCHS or Legal Representative of the patient, authorize the release of verbal and written medical information regarding my treatment, care and updates on my condition to the following individuals.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ **Date:** _____

***This* form should be updated annually or upon the request of the patient. This form is to be scanned into the patient's medical record. All verbal discussions must be documented in the patient's medical record.**

Financial Responsibility Agreement

Thank you for choosing Columbia County Health System (Dayton General Hospital, Columbia Family Clinic, Waitsburg Clinic, College Place Health Clinic) for your healthcare needs. We are committed to providing quality care and services to all our patients**. Please thoroughly read and initial the statements** below to acknowledge that you understand this Financial Responsibility Agreement. This agreement is valid for **one year** from the date of responsible party's signature.

_____ **Initial** I will provide CCHS with current and accurate health insurance information. I understand that providing a copy of my insurance card does not guarantee coverage.

_____ **Initial** I understand that I am responsible for services not covered by insurance and for amounts applied to my deductible, coinsurance, or copay. If I am uninsured or choose not to bill my insurance, I understand that I am financially responsible for all services rendered.

_____ **Initial** I understand that balances are due and payable within 30 days from my first billing statement. I understand that if I am having difficulty with paying my bill, would like to set up payment arrangements, or would like to apply for financial assistance, that I need to contact the ***Billing Office at 509-382-2531*** during normal business hours are Monday through Friday between 8 a.m. and 4:30 p.m.

_____ **Initial** I understand that a $25.00 charge will be added to my account for any check returned by my bank for any reason. This will be in addition to charges made by my bank, if any

_____ _____

Patient or Parent/Guardian Signature ***Date***

_____ _____

Patient or Parent/Guardian Printed Name ***Relationship to Patient***

Columbia County HEALTH SYSTEM

Dayton General Hospital	Columbia Family Clinic	Waitsburg Clinic	College Place Clinic	Rivers Walk Assisted Living Facility
P: 509-382-3205	P: 509-382-3200 F: 509-382-2748	P: 509-382-3200 F: 509-337-6011	P: 509-382-8349 F: 509-593-4342	P: 509-382-4911 F: 509-593-4911

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ MR#_____

Address:_____Telephone:_____

Previous Name(s): _____Birth Date: _____

Date Requested By: _____Upcoming Appointment: ☐ Yes ☐ No

Hereby Authorize:

_____

(Individual/Agency)

_____

(Address)

_____

(City, State, Zip Code)

To Provide Medical Information to:

_____

(Individual/Agency)

_____

(Address)

_____

(City, State, Zip Code)

Permission to fax and/or send electronically ☐No ☐Yes - Email and/or Fax: _____

Dates of Treatment: _____

Data Requested: _____

☐Physician Notes ☐Operative Reports ☐Lab/Pathology Report

☐History & Physical ☐X-Rays ☐EKG ☐ Reports

☐All Health Care Records ☐Films ☐Other:_____

For the purpose of:_____

To be valid, this authorization must be dated within 90 days of the request for information. This authorization may be revoked in writing at any time, provided that the information has not been released. To view the process for revoking this authorization please read the Privacy Notice to our patients. Once Columbia County Health System discloses health information, the person or organization that receives it may redisclose it, at which time it may no longer be protected under Privacy laws. The patient understands that they do not have to sign this authorization to receive health care benefits.

_____ _____

Patient Signature Date/time Parent/ Legal Guardian or Authorized representative*

_____Witnessed

By checking and signing below, I specifically authorize the release of the following confidential information.

☐ HIV test, Test Results, and Related Information

☐Sexually Transmitted Diseases

☐ Drug/Alcohol Diagnosis, Treatment or Referral Information

☐ Psychiatric Disorders/Mental Health

_____ _____

Patient Signature Date/Time Parent/Legal Guardian or Authorized Representative* Date/Time

Please provide documentation to prove authority to sign on behalf of the patient