



**CLEARWATER MEDICAL CLINIC**

# NEW PATIENT FORM

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please check below if there is a specific provider you would like to see.*

- Celso Chavez, MD
- Doris Ziegeldorf, FNP-BC
- Robin Hight, NP-C
- Cheryl Loetscher, NP-C
- Theresa Smith, NP-C
- Christine Norwood, NP-C
- Cody Harris, DNP
- Jessi Six, FNP-BC
- Sherry Sweikert-Smith, DNP

### Patient Information (as it appears on insurance card)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_ Alt Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_  
 Email \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Other Last Name(s) Used \_\_\_\_\_ Preferred Language \_\_\_\_\_  
 Race  African American  Alaska Native  American Indian  Caucasian  Hispanic or Latino  Native American  Other \_\_\_\_\_  
 Guarantor (Full Name) \_\_\_\_\_ Guarantor Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

### Insurance Information

Primary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_  
 Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_

### Employer Information

Employer Name \_\_\_\_\_ Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  Full-time  Part-time

### Reason for Visit/Establishing Care - Current/Past Medical Problems

Accident Related?  Yes  No Previous Primary Care Provider \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 How often do you go to the doctor in a year? \_\_\_\_\_ Do you have any family members that see one of our providers?  Yes  No  
 Who recommended you to our clinic or how did you hear about us? \_\_\_\_\_

### Allergies - Please list any allergy or intolerance you have to medications or environment (i.e. dust, nuts, animals)

Medication or Environmental Issue	Reaction

### Current Medications - Include all prescription and non-prescription (over-the-counter) medications

Medication Name	Dose (mg, mcg, %)	How Often?

If you are not currently taking any medications (prescription or over-the-counter), check here



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**Past Medical History**

Have you had a colonoscopy?  Yes  No If yes, when? \_\_\_\_\_ Providers Name \_\_\_\_\_

Women: Age when menses began \_\_\_\_\_ If post-menopausal, when was your last period? \_\_\_\_\_

At what age did you have your first child? \_\_\_\_\_ Total number of pregnancies \_\_\_\_\_ Miscarriages? \_\_\_\_\_

**Have you had any of the following? (list type if requested)      Yes      No      Date Issue Began**

Have you had any of the following? (list type if requested)	Yes	No	Date Issue Began
Acid Reflux			
Anemia			
Anxiety			
Arthritis			
Asthma			
Bleeding Tendency			
Blood Clots			
Blood Disorder - Type?			
Bowel Disease - Type?			
Cancer - Type?			
Chronic Muscle Pain			
Daytime Sleepiness			
Depression			
Diabetes - Type?			
Gallbladder Problems			
Gout			
Heart Trouble			
Hepatitis - Type?			
Hereditary Defect - Type?			
High Blood Pressure			
High Cholesterol			
Insomnia			
Joint Pain			
Kidney Failure			
Kidney Stones			
Liver Disease			
Lung Problems - Type?			
Migraines			
Osteoporosis			
Pancreatitis			
Rheumatic Fever			
Seizures			
Sexually Transmitted Disease - Type?			
Stomach Ulcers			
Stroke			
Substance Abuse Disorder - Type?			
Thyroid Gland Trouble			
Tuberculosis (TB) - Exposure or Contracted?			
Ulcers - Type?			

Other - Please Describe:



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Additional Medical Issues	Year Issue Began

Past Surgeries - List Type of Surgery	Year

Immunization History - Do not fill out unless you have specific dates	Month/Day/Year
Pneumovax (Pneumonia Vaccine)	
Zostavax (Shingles Vaccine)	
Tetanus	
PPD (Tuberculin Skin Test)	
Hepatitis A	
Hepatitis B	
Meningococcal	
MMR (Measles, Mumps, Rubella Vaccine)	
Varicella (Chickenpox Vaccine)	
Other - Please List:	

Family History - List which relative (i.e. mother, father, brother, sister, aunt, uncle, maternal/paternal grandparent, etc.)		
Illness	Family Members (please list)	If grandparent, maternal or paternal?
Arthritis		
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		
Heart Attack		
Migraines		
Seizures		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		



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### Social History

Marital Status (please choose)  Single  Married  Separated  Divorced  Widowed

Do you smoke?  Yes  No Frequency? \_\_\_\_\_ Did you smoke in the past?  Yes  No

How many years did you smoke? \_\_\_\_\_ When did you quit smoking? \_\_\_\_\_

Do you use smokeless tobacco?  Yes  No Frequency? \_\_\_\_\_ Did you use smokeless tobacco in the past?  Yes  No

How many years did you use smokeless tobacco? \_\_\_\_\_ When did you quit using smokeless tobacco? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much/frequency? \_\_\_\_\_

Do you smoke marijuana?  Yes  No How much/frequency? \_\_\_\_\_

Do you use recreational drugs?  Yes  No Type \_\_\_\_\_ How much/frequency? \_\_\_\_\_

### My Health Portal

*My Health Portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information such as, recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results, upcoming radiology appointments, and more.*

Have you signed up for My Health Portal?  Yes  No If no, please check here if you would like to sign-up

### Pharmacy Preference

Pharmacy Name \_\_\_\_\_

Pharmacy Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax # \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Please complete this form and send to:

**MAIL:** Tri-State Clearwater Medical Clinic  
 ATTN: New Patient Coordinator  
 1522 17th Street  
 Lewiston, Idaho

**FAX:** 208.743.4642

**EMAIL:** cseay@tsmh.org

**Questions?** Please contact the New Patient Coordinator at 208.743.8416 ext. 4225 or email cseay@tsmh.org