



New Patient Coordinator
 Phone: 509.769.2014
 Email: newpatients@tsmh.org

Family Medicine	<input type="checkbox"/> Warren Ellison MD	
<input type="checkbox"/> Tyler Anderson PA-C	<input type="checkbox"/> Don Greggain MD	
<input type="checkbox"/> Tamara Bruns DNP, ARNP	<input type="checkbox"/> Jeremy Ostermiller PA-C	Internal Medicine & Primary Care
<input type="checkbox"/> Jennifer Creaser ARNP	<input type="checkbox"/> John Rudolph DO	<input type="checkbox"/> Christopher Iacobelli MD
<input type="checkbox"/> Mary Crowell DO	<input type="checkbox"/> Carson Seeber MD	

Patient Information (as it appears on insurance card)

Patient Name _____ Date of Birth _____ M F
 Mailing Address _____ City _____ State/Zip _____
 Phone Number _____ Alt Phone Number _____
 Email _____ Social Security # _____
 Guarantor (Full Name) _____ Guarantor Social Security # _____

Emergency Contact

Name _____ Phone _____
 Relationship to Patient _____

Insurance Information

Primary Insurance _____ Subscriber Name _____
 Policy/ID # _____ Group # _____ Phone # _____
 Secondary Insurance _____ Subscriber Name _____
 Policy/ID # _____ Group # _____ Phone # _____

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

Accident Related? Yes No Previous Provider _____ Date Last Seen _____
 How often do you go to the doctor in a year? _____ Do you have family members that see one of our providers? _____
 Who recommended you to our clinics 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, etc.)

Medication or Environmental Issue	Reaction

Current Medications Including all prescription and non-prescription (over-the-counter) medications
 If you are not currently taking medications (prescription or over-the-counter), check here

Medication Name	Dose (mg, mcg, %)	How often do you take?

Patient's Name: _____

Past Medical History

Have you had a colonoscopy? Yes No If yes, date: _____ Physician's name: _____

Women: Age when menses began: _____

If postmenopausal, 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 Problem Began
Acid Reflux			
Anemia or Other Blood Disorder			
Anxiety			
Arthritis			
Asthma or Lung Problems			
Bleeding Tendency			
Blood Clots			
Cancer - Type?			
Chronic Muscle Pain			
Daytime Sleepiness			
Depression			
Diabetes - Type?			
Gallbladder Problems			
Gout			
Heart Trouble			
Hepatitis			
Hereditary Defect - Type?			
High Blood Pressure			
High Cholesterol			
Insomnia			
Joint Pain			
Kidney Failure			
Kidney Stones			
Liver Disease			
Migraines			
Osteoporosis			
Pancreatitis			
Rheumatic Fever			
Seizures			
Sexually Transmitted Disease - Type?			
Stomach Ulcers			
Stroke			
Substance Abuse Disorders - Type?			
Thyroid Gland Trouble			
Tuberculosis (TB)			
Ulcers or Bowel Disease			
Other - Please describe:			

Patient's Name: _____

Additional Medical Problems	Year Began

Past Surgeries	
Type of Surgery	Year

Immunization History	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 listed, maternal or paternal?
Arthritis		
Cancer (what type?)		
Dementia		
Diabetes		
High Blood Pressure		
Heart Attack		
Migraines		
Seizures		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		

Patient's Name: _____

Social History

Marital Status (please choose one) Single Married Separated Divorced Widowed

Do you smoke? Yes No How much? _____ Did you smoke in the past? Yes No

How many years of smoking? _____ When did you quit? _____

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? _____

Have you used recreational drugs in the past? Yes No Type/How much/Frequency? _____

What is your pharmacy preference? _____

Additional Comments: _____

Please complete this form and return:

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Clarkston, WA 99403

(By Fax) FAX: 509.769.2015

(By Email) EMAIL: newpatients@tsmh.org

Questions? Please call the New Patient Coordinator at 509.769.2014