Family Medicine	☐ Warren Ellison MD	
☐ Tyler Anderson PA-C	☐ Don Greggain MD	
☐ Tamara Bruns DNP, ARNP	☐ Jeremy Ostermiller PA-C	**Internal Medicine & Primary Care**
☐ Jennifer Creaser ARNP	☐ John Rudolph DO	☐ James B. Fisher MD
☐ Mary Crowell DO	☐ Carson Seeber MD	☐ Christopher Iacobelli MD

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

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 (Tubuerculin 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:

(By Mail) Tri-State Memorial Hospital
ATTN: New Patient Coordinator
1221 Highland Avenue
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