Tri-State Memorial Hospital & Medical Campus

# NEW PATIENT FORM

Patient Name _____ Date ____/____/_____

## Tri-State Family Practice

Which clinic location do you prefer to be seen in? Clarkston ❑ Lewiston ❑ Either ❑

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

| Tri-State Family Practice Clarkston | | Tri-State Family Practice Lewiston |
|---|---|---|
| ❑ Tyler Anderson, PA-C | ❑ Heather Davis-Remacle, PA-C | ❑ Jennifer Creaser, ARNP |
| ❑ Jeremy Ostermiller, PA-C | ❑ Luke Megna, MD, FAAFP | ❑ Mary Crowell, DO |
| ❑ Carson Seeber, MD | ❑ John Merrill, DO | ❑ John Rudolph, DO |
| | | ❑ Alexa Rhea, PA-C |

## 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 |
|---|---|---|---|
| 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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Patient Name _____ Date ____/____/_____

| Additional Medical Issues | Year Issue Began |
|---|---|
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| Past Surgeries - List Type of Surgery | Year |
|---|---|
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| | |

| 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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Patient Name _____ Date ____/____/_____

## 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 Memorial Hospital
ATTN: New Patient Coordinator
1221 Highland Avenue
Clarkston, WA 99403

FAX: 509.769.2015

EMAIL: newpatients@tsmh.org

**Questions?** Please contact the New Patient Coordinator at 509.769.2014 or newpatients@tsmh.org