



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

### Tri-State Family Practice

Which location do you prefer to be seen in?  Clarkston  Lewiston  Clearwater  Any Provider: \_\_\_\_\_

### 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 # \_\_\_\_\_

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 \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### Employer Information

Employer Name \_\_\_\_\_ Phone # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

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

Accident Related?  Yes  No Previous Primary Care Provider \_\_\_\_\_

### 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?	Managed By

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



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## Past Medical History

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? \_\_\_\_\_

## Health Conditions/Concerns


## Past Surgeries/Procedures - List Type

Year

Past Surgeries/Procedures - List Type	Year

## Where were your previous vaccines or immunizations completed?


## 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?
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		

## Social History

Marital Status (please choose)  Single  Married  Separated  Divorced  Widowed  
 Do you use tobacco products?  Yes  No Frequency? \_\_\_\_\_ Did you use tobacco products in the past?  Yes  No  
 How many years did you use tobacco products? \_\_\_\_\_ When did you quit using tobacco products? \_\_\_\_\_  
 Do you drink alcohol?  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.*

## Pharmacy Preference

Pharmacy Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_



**Tri-State**  
Memorial Hospital &  
Medical Campus

# NEW PATIENT FORM

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

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](mailto:newpatients@tsmh.org)

**Questions?** Please contact the New Patient Coordinator at 509.769.2014 or [newpatients@tsmh.org](mailto:newpatients@tsmh.org)