NEW PATIENT FORM

Patient Name _____ Date ____/____/_____

Tri-State Family Practice

Which location do you prefer to be seen in? ❑ Clarkston ❑ Lewiston ❑ Any Provider: _____
❑ Clearwater Clinic ❑ Suboxone Only

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 ____/____/_____
Insurance ID # _____ Group # _____
Secondary Insurance _____ Subscriber Name _____ Date of Birth ____/____/_____
Insurance ID # _____ Group # _____
Subsciber # _____ Policy #_____

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 ❑

Tri-State Health Services

Tri-State Memorial Hospital & Medical Campus

NEW PATIENT FORM

Patient Name _____ Date ____/____/_____

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

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

Type of tobacco products ❑ Cigarette ❑ Vape ❑ Smokeless ❑ Chewing tobacco

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 Health Services

Tri-State Memorial Hospital & Medical Campus

NEW PATIENT FORM

Patient Name _____ Date ____/____/_____

Additional Comments: _____

_____

_____

_____

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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