BRIDGEPORT FAMILY MEDICINE
NEW PATIENT FORMS

DEMOGRAPHICS

Today's Date: _______/_________/________

Patient's Name: ____

Last | First | M. I.

Preferred Name (Nickname): ______________________________________

Date of Birth: _______/_________/________ SSN: __________ - _______ - ______________

Age: __________________

Gender: ❑ Female ❑ Male ❑ Prefer not to answer

Primary Phone Number: ❑ Cell ❑ Home ❑ Work

Is it OK to leave a detailed voicemail at the above phone number? ❑ Yes ❑ No

Email Address:

Is it OK to send a detailed message to the above email address? ❑ Yes ❑ No

Mailing Address:

Emergency Contact: Relation:

Emergency Phone Number:

Preferred Pharmacy: ______________________________________

Pharmacy Address: ____

How did you hear about our clinic?

INSURANCE INFORMATION

Insurance Company/Carrier: ______________________ Policy Number: ____________________

Guarantor's (Primary Policyholder's) Name: ______________________________________

Date of Birth: _______/_________/________ SSN: __________ - _______ - ________

Relation to Patient: ________________________________

Mailing Address (if different from above):

Guarantor Phone Number:

Patient's Name: ____

Last First M. I.

ALLERGIES

Medication Allergies: ❑ No ❑ Yes

If yes, please list medication and reaction below:

____

____

____

CURRENT MEDICATIONS

Please list all medications that you are taking. Include non-prescription medications, vitamins, or supplements.

Name of Medication	Dosage (i.e. strength in mg)	Instructions (i.e. pills per day)

SOCIAL HISTORY

Occupation:

Relationship Status:

Are you sexually active? ❑ Yes ❑ No

Do you use contraception? ❑ Yes ❑ No If yes, what kind? ____________

Partner(s) are: ❑ Male ❑ Female ❑ Both

Do you currently drink alcohol? ❑ Yes ❑ No If yes, how many drinks per week? ________

Do you currently smoke or chew tobacco? ❑ Yes ❑ No If yes, how many packs per day? ________

Did you regularly use tobacco in the past? ❑ Yes ❑ No If yes, how long did you smoke/chew? ________

Previous packs per day: ________

Quit date: ________

Do you currently use any recreational drugs? ❑ Yes ❑ No If yes, what kind? ____________

Did you regularly use drugs in the past? ❑ Yes ❑ No If yes, what kind? ____________

How long did you use? ____________

Have you used IV drugs? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Please list previous surgeries below: Year:

______________________________ ________

______________________________ ________

______________________________ ________

Do you now or have you ever had?

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Migraines
- ❑ Cancer (type) ____________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema/COPD
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Arthritis
- ❑ Seasonal allergies
- ❑ Stomach or peptic ulcer
- ❑ Heartburn/GERD
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Depression/Anxiety

Other medical conditions (please list):

Are you established with any specialists (e.g., cardiologist, pulmonologist) to manage the above condition(s)? If so, please list below:

FAMILY HISTORY	
Illness:	Relationship to patient:
❑ Anemia or blood disease	
❑ Cancer	
❑ Breast cancer	
❑ Ovarian cancer	
❑ Endometrial/uterine cancer	
❑ Colon cancer	
❑ Pancreatic cancer	
❑ Prostate cancer	
❑ Gastric/stomach cancer	
❑ Melanoma	
❑ Other cancer (please list) ____________	
❑ Diabetes	
❑ Glaucoma	
❑ High blood pressure	
❑ High cholesterol	
❑ Heart attack (MI)	
❑ Stroke	
❑ Depression/anxiety	
❑ Other mental illness (please list)	
❑ Other (please list)	

PREVENTATIVE CARE	
Date of last physical exam (wellness visit):	____________
Date of last Tdap vaccine (tetanus shot):	____________
Date of last influenza vaccine (flu shot):	____________
Date of last dental exam:	____________
Date of last colonoscopy (may not be applicable):	____________
	____________
If female:	
Date of last Pap smear:	____________
Date of last mammogram:	

Patient Acknowledgement and Financial Form

FINANCIAL POLICY Initials_____Bridgeport Family Medicine values the confidence you have shown in choosing us as your healthcare provider. You should be aware of what services your insurance may or may not cover. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill, including deductibles, co-payment, co-insurance and noncovered services as determined by your contract with you insurance carrier. **Co-pays are due at the time of service.** If you are unable to furnish us with current insurance information at the time of service, charges will become your responsibility. We may require a deposit for certain services. You will receive a monthly statement showing the activity and balances due on your account. Bridgeport Family Medicine accepts cash, checks, and credit/debit cards. Unless payment arrangements have been made in advance, any remaining balance owed by you is due in full when you receive your first bill. We offer a payment plan option for qualified patients who are unable to pay their balance in full. **Patient balances left unpaid may be turned to an outside collections agency which will incur a 30% charge.**Separate billings may be received for laboratory,radiology, or other providers who are involved in your care which are subject to their financial policies.

NO-SHOW & CANCELLATION POLICY Initials____ As a courtesy to Bridgeport Family Medicine, we request 24 Hours' notice for any office appointment you will not be able to keep. Failure to provide timely notice, or repeatedly neglecting to show up for your scheduled appointment(s), may result in termination from the practice.

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT & CONSENT Initials_____ I understand that Bridgeport Family Medicine will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree the Bridgeport Family Medicine may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Bridgeport Family Medicine will handle health information about me. This written description is known as the Notice of Privacy Practices and may be revised from time to time, and that I am entitled to receive a copy of any revision. I also understand that a copy of the most current version of the Notice of Privacy Practices will be posted in reception areas. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Bridgeport Family Medicine is not required by law to agree to such requests.

BENEFIT ASSIGNMENT By signing below, I authorize Bridgeport Family Medicine to bill my insurance on my behalf, and assign all benefits, if any, directly to Bridgeport Family Medicine, that otherwise would be payable to me for services rendered. I authorize the use of my signature on all insurance submissions. This consent will continue indefinitely unless revoked by me in writing.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE By signing below, I acknowledge that I have read and understand all information included in this policy.

____

Patient/Patient Representative Signature   Relationship (if not patient)   Date

If you have any questions about this policy, please see a representative in our office. We appreciate the opportunity to serve you.

Rev. 10/2019

HIPAA Right of Access Authorization: (For Family Members and Friends)

As required by privacy laws, Bridgeport Family Medicine will not disclose your protected health information without your consent.

I, ________________________________, hereby authorize my health care and medical services providers and payers to disclose and release my protected health care status or health care information with:

Name: Relationship: Phone:

____

____

Name of the Patient / Individual Giving this Authorization:

____*Date of birth*________________

Signature of the Individual Giving this Authorization:

____*Date*________________

- ❑ *OK to leave a detailed voicemail*
- ❑ *OK to leave a detailed email*
- ❑ *Do not leave detailed messages*

Dr. Michael Phelps
Dr. Stan Adamek

16083 SW Upper Boones Ferry Road, Suite 130, Tigard, OR 97224
Phone: (503) 603-9087 Fax: (503) 603-9122

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________

Previous Name: ______________________________

I request and authorize;

Physician Name: ________________________ Office Name: ____________________

Fax number: _____________________ Office Phone number: ____________________

to release healthcare information of the patient named above to:

Name: Bridgeport Family Medicine ________________________________

Address: 16083 SW Upper Boones Ferry Road Suite 130 _______________

City: Tigard _____________________ State: OR _____ Zip Code: 97224 ________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Yes ☐ No

Patient Signature: ______________________________________ Date Signed: ____________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.