Todays Date : _____

Patient Name: Last _____ First _____ Middle _____

Soc Sec Num : ___-___-_____ Date of birth _____ Gender F M

What is the reason for your visit today?

_____

Race : Asian Black/African American American Indian Alaskan Native

Hawaiian/Pacific Islander White/Caucasian Decline

Ethnicity : Hispanic/Latino Non-Hispanic/Latino

Street Address _____ City _____ State OR ZIP _____

Mailing Address _____ City _____ State OR ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Contact Method Home Cell Work Message OK? Home Cell Work

Emergency Contact _____ Phone # _____ Relationship _____

Spouse's Name _____ Phone# _____

Employer _____

Primary Insurance Company _____ ID/Policy # _____

Policy Holder _____ SSN ___-___-_____ DOB _____

Secondary Insurance Company _____ ID/Policy # _____

Policy Holder _____ SSN ___-___-_____ DOB _____

Preferred Pharmacy Name _____ City _____

Secondary Pharmacy Name _____ City _____

Todays Date: _____ Patient's Name: _____ Date of Birth _____

Please list all Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months), or from whom you have received prescriptions.

Provider/Clinic Name	Phone Number

Please list all of your current medications:

Medication	Prescribed By	Dose	Frequency

Please list and describe allergic reactions you have had to food, medications or insect stings:

Allergy	Reaction

Vacination History: Have you ever had any of the following vaccinations?

Influenza	Yes	No	If Yes, when?	_____
Pneumonia	Yes	No	If Yes, when?	_____
Tetanus	Yes	No	If Yes, when?	_____
BCG	Yes	No	If Yes, when?	_____
Varicella	Yes	No	If Yes, when?	_____
HPC (Gardasil)	Yes	No	If Yes, when?	_____

Todays Date: _____ Patient's Name: _____ Date of Birth _____

Tobacco/Marijuana/Alcohol History

Have you ever: smoked tobacco? chewed tobacco? smoked marijuana?

Do you currently smoke tobacco? Yes No

If yes, how often? _____ _____ # of years If you quit, when? _____

Do you currently chew tobacco? Yes No

If yes, how often? _____ _____ # of years If you quit, when? _____

Do you currently smoke marijuana? Yes No

If yes, how often? _____ _____ # of years If you quit, when? _____

Surgical History: Major surgeries or procedures only.

Procedure	Date	Complications?

Family History: Please indicate any major illnesses or health conditions that IMMEDIATE family has had.

Relative	Living	Age	Health Conditions	Deceased	Cause of Death
Mother					
Father					

Todays Date: _____ Patient's Name: _____ Date of Birth _____

Past Medical History

Please mark any of the following that you have or have had in the past:

Head			**Genitourinary**		
Trauma	Yes	No	Hernia	Yes	No
Eyes			Incontinence	Yes	No
Blindness	Yes	No	Nephrolithlasis	Yes	No
Cataracts	Yes	No	Other Kidney Disease	Yes	No
Glaucoma	Yes	No	STD's	Yes	No
Wears Glasses/Contacts	Yes	No	UTI	Yes	No
Ears			**Musculoskeletal**		
Hearing Aids	Yes	No	Arthritus	Yes	No
Nose/Sinus			Gout	Yes	No
Allergic Rhinitis	Yes	No	M/S Injury	Yes	No
Sinus Infection	Yes	No	**Skin**		
Mouth/Throat/Teeth			Dermatitus	Yes	No
Dentures	Yes	No	Mole	Yes	No
Cardiovascular			Other Skin Condition	Yes	No
Aneurysm	Yes	No	Psoriasis	Yes	No
Angina	Yes	No	**Neurological**		
DVT	Yes	No	Epilepsy	Yes	No
Dysrhythmia	Yes	No	Seizures	Yes	No
Hypertension/HNT	Yes	No	Headaches/Migraines	Yes	No
Murmer	Yes	No	Stroke	Yes	No
Myocardial Infarction (Heart Attack)	Yes	No	TIA	Yes	No
Other Heart Disease	Yes	No	**Psychiatric**		
Respiratory			Bipolar Disorder	Yes	No
Asthma	Yes	No	Depression	Yes	No
Bronchitis	Yes	No	Hallucinations, Delusions	Yes	No
COPD	Yes	No	Suicidal Ideas/Attempts	Yes	No
Pleuritis	Yes	No	**Endocrine**		
Pneumonia	Yes	No	Goiter	Yes	No
Gastronintestinal			Hyperlipidemia	Yes	No
Cirrhosis	Yes	No	Hypothroidism	Yes	No
GERD	Yes	No	Thyroid Disease	Yes	No
Gallbladder Disease	Yes	No	Thyroiditis	Yes	No
Heartburn	Yes	No	Type I DM	Yes	No
Hemorrhoids	Yes	No	Type II DM	Yes	No
Hepatitis	Yes	No	**Hematology/Oncology**		
Hiatal Hernia	Yes	No	Anemia	Yes	No
Jaundice	Yes	No	Cancer	Yes	No
Ulcer	Yes	No	**Infectious**		
			HIV	Yes	No
			Tuberculosis (DX or Exposure)	Yes	No

Todays Date: _____ Patient's Name: _____ Date of Birth _____

REVIEW OF SYSTEMS

Please circle any of the following that you have experienced in the past 2 weeks.

Constitutional:	Fever, night sweats, chills, cold intolerance, fatigue, daytime drowsiness, weight gain, weight loss, change in appetitie, change in thirst
Eyes:	Changes in vision, loss of vision, blurred vision, diplopia, eye redness, eye pain, tearing
Ears:	Difficulty hearing, hearing loss, ear pain, ear drainage, ringing in ears
Nose:	Nasal congestion, nasal discharge, epistaxis, sneezing, snoring
Mouth/Throat:	Lip sores, mouth sores, tongue sores, sore throat, difficulty swallowing, pain with eating, gum bleeding, dental problems, hoarse voice
Neck:	Neck pain, neck stiffness, neck lumps, neck swelling
Lungs:	Shortness of breath, cough, productive cough, bloody cough, wheezing
Heart:	Chest pain, palpitations, shortness of breath at rest or activity, sit up to sleep/breathe, night time shortness of breath, swelling in lower legs, varicose veins
Breast:	Lump, pain, nipple discharge
GI:	Abdominal pain, rectal pain, nausea, vomiting, vomiting blood, gas, more frequent BM's, constipation, less frequent BM's, diarrhea
Bladder:	Pain with urination, blood in urine, difficulty starting stream, change in urine stream, incontinence
Genital:	Decreased libido, sexual dysfunction, pain with intercourse, pain with mensus, abnormal mensus
Skin:	Hair loss, dry skin, itching, hives, rash, bruising, new moles
Muscles:	Muscle pain, back pain, tender points, muscle cramps, muscle weakness, decreased strength, paralysis, difficulty walking, limp
Nerves:	Headaches, vertigo/dizziness, fainting, numbness, tingling, lack of coordination, difficulty speaking, memory loss
Mental:	Change in mood, depression, sadness, anxiety, nervousness, insomnia, suicidal/homicidal thoughts, hoplessness, worthlessness, delusions, hallucinations
Bleeding/Lymph Nodes:	Easy bruising, difficulty stopping blood flow, lymph node enlarged, lymph node tender

Todays Date: _____ Patient's Name: _____ Date of Birth _____

AUTHORIZATION FOR TREATMENT, BILLING OF INSURANCE & RELEASE OF INFORMATION

I hereby consent to treatment by clinic providers for myself or the person listed above. I authorize any holder of medical or other information about me to release to my insurance company or the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers any information needed for this or relates to Medicare or other systems. I permit a copy of this authorization to be used in place of the original, and request payment of Medicaid insurance benefits either to myself or the party who accepts assignment.

I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment, including health insurance and other medical plans.

Signature _____ Date _____

Relationship to Patient _____

Todays Date: _____ Patient's Name: _____ Date of Birth _____

HIPPA Compliance Patient Consent Form

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA (Health Insurance Portability and Accountability Act 1996), we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only allow information to be given to family members indicated below.

I authorize Laura Johnson, N.P., P.C. to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature: _____ Date: _____

Todays Date: _____ Patient's Name: _____ Date of Birth _____

Primary Care
Cancellation and No-Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel please give us a 24-hour notice. This will enable another patient who is waiting for an appointment to be scheduled in your slot.

Patients who do not show up for their scheduled appointment without 24-hour cancellation notice are considered a NO-SHOW and may be charged a $25 NO-SHOW fee.

The NO-SHOW fees are the sole responsiblity of the patient and must be paid in full before the patient can be seen again.

We understand special circumstances may arise and cause you to cancel with less than 24-hour notification. In this instance, the cancellation fee MAY be waived with management approval only.

We believe that a good Provider/Patient relationship is based upon understanding and communication.

Please sign that you have read, understand and agree to our Cancellation and NO-SHOW Policy.

Patient Signature or Patient Representative: _____

Todays Date: _____ Patient's Name: _____ Date of Birth _____

MEDICAL RECORDS REQUEST

You may use or disclose the following health care information (please check one):

All health care information in my medical records

Specific information regarding the following issues(s) or date(s): _____

I understand that my consent is required to release any of the specific health care information listed below. By initialing each of the following, I consent to the disclosure of those records:

HIV/AIDS STDs Mental Health Genetic Testing Drug/alcohol

I REQUEST & AUTHORIZE:

Provider/Practice: _____
City/State: _____
Phone: _____ Fax: _____

TO RELEASE THE SPECIFIED RECORDS TO:

Laura L. Johnson, NP PC
1619 NW Hawthorne Ave, Suite 204
Grants Pass, Oregon 97526
Phone: 541-916-8530 Fax: 541-916-8533

Reason(s) for this authorization: At my request Changing Primary Care Providers Other

I understand I do not have to sign this authorization in order to get health care benefits. I may revoke this authorization at any time in writing and it will not affect any actions already taken based upon this authorization. To revoke this authroization, contact to fill out a revocation form. Once health care information is disclosed, the person or organization may re-disclose it. Privacy laws may no longer protect it. If the information disclosed from Laura L. Johnson, NP PC Family Practive was not generated by a provider of this clinic we will not be liable for the contents of those records. This authorization will expire in 90 days or upon completion.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed Name **Relationship (parent, self, etc.)**

Revised date: 4/25/2022