Jackson Whole Family Health

1110 Maple Way | PO Box 10738, Jackson, WY 83002 | Phone (307) 733-7003 | Fax (307) 734-8477

PATIENT INFORMATION:

Name (Last)_____ (First)_____ (MI)_____
(Nombre: Apellidos) *(Primero)* *(Segundo)*

Mailing Address_____ City_____ State_____ Zipcode_____
(Direccion Postal) *(Ciudad)* *(Estado)* *(C.P.)*

Physical Address_____ City_____ State_____ Zipcode_____
(Direccion Fisica) *(Ciudad)* *(Estado)* *(C.P.)*

Home Phone #_____ Work Phone #_____ Cell#_____
(Telephonos: Casa) *(Trabajo)* *(Celular)*

Social Security#_____ Date of Birth_____ Marital Status: S M D W Sex: M F
(Seguro Social) *(Fecha de nacimiento)* *(Estado Civil) S C D V*

E-Mail_____ Personal MD_____
(Correo Electronico) *(Medico Personal)*

Employer_____ I give permission to leave detailed messages at: Home Work Cell
(Empleador) *(Autorizo dejar mensajes detallados): Casa Trabajo Celular El Puente*

If minor, names of parental guardians_____ Pharmacy you use_____
(Si es Menor, anota nombres de los padres) *(Farmacia Preferida)*

Spouse's Name_____ Spouse's Date of Birth_____ Spouse's Employer_____
(Nombre de su Pareja) *(Su fecha de Nacimiento)* *(Su Empleador)*

Names and ages of children_____
(Nombres y edades de sus hijos)

How did you hear about us?_____
(Como se entero de nosotros?)

INSURANCE INFORMATION: (*Seguro Medico*)

Primary Insurance Company _____

Subscriber's Name _____ Insurance ID# _____ Group# _____

Subscriber's Date of Birth_____ Subscriber's Social Security Number_____

Secondary Insurance Company _____

If you have your card with you, we will make a copy of it to put on file.

EMERGENCY CONTACT INFORMATION: (Other than spouse)

(*En caso de emergencia, aparte de su pareja*)

Name_____ Relationship_____
(Nombre) *(Parentesco)*

Home Phone #_____ Work Phone #_____ Cell Phone #_____
(Telefonos: Casa) *(Trabajo)* *(Celular)*

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges, legal fees, whether or not covered by Medicare or Workman's Compensation. I authorize payment of medical benefits to *Jackson Whole Family Health* for services provided. I authorize the release of information, including my medical records, necessary to process insurance, and give *Jackson Whole Family Health* consent for treatment.

Signature(*Firma*)_____ Date (*Fecha*)_____

Jackson Whole Family Health
Charlotte Mason DNP,FNP,BC
Family Practice and Urgent Care

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to.

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient:: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date_____Initials_____Reason_____

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1110 Maple Way
Jackson, WY 83001
(307) 733-7003

1. **Main reason for today's visit:**

   Other concerns:

   Where were you receiving care before (who is your primary care provider)?

   In the past 2 weeks have you been bothered by:

   Little interest or pleasure in doing things? Yes or No (please circle)

   Feeling down, depressed, or hopeless? Yes or No (please circle)

2. **Review of Systems:** Please mark the box of any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you.

General ☐ Unexplained weight loss/gain ☐ Unexplained fatigue/weakness ☐ Fever, chills ☐ No problems	Respiratory ☐ Cough/wheeze ☐ Loud snoring ☐ Shortness of breath with exertion ☐ No problems	Hematologic/Lymphatic ☐ Swollen glands ☐ Easy bruising ☐ No problems
Skin ☐ New or change in mole ☐ Rash/itching ☐ No problems	Gastrointestinal ☐ Heartburn/reflux ☐ Change in bowl movements ☐ Blood in stool ☐ No problems	Allergic/immune ☐ Hay fever/allergies ☐ Frequent infections ☐ No problems
Breast ☐ Breast lump/pain ☐ Nipple discharge ☐ No problems	Genitourinary ☐ Leaking urine ☐ Blood in urine ☐ Nighttime urination ☐ Penile/Vaginal discharge ☐ Concern with sexual function ☐ No problems	Neurological ☐ Headache ☐ Memory loss ☐ Fainting ☐ Dizziness ☐ Numbness/tingling ☐ Unsteady gait ☐ No problems
Eyes/Ears/Nose/Throat ☐ Nosebleeds ☐ Difficulty swallowing ☐ Frequent sore throat ☐ Change in vision/hearing ☐ No problems	Musculoskeletal ☐ Neck pain ☐ Back pain ☐ Muscle/joint pain ☐ No problems	Psychiatric ☐ Anxiety/irritability ☐ Sleep problems ☐ Lack of concentration ☐ No problems
Cardiovascular ☐ Chest pain/discomfort ☐ Fast/irregular heartbeat ☐ No problems	Endocrine ☐ Heat or cold sensitivity ☐ Change in hair/skin ☐ Excessive thirst ☐ Frequent urination ☐ No problems	Women only ☐ Pre-menstrual symptoms ☐ Irregular or heavy periods ☐ Hot flashes/night sweats ☐ No problems

Medications: Please list all prescription or non-prescription medications (vitamins, supplements, etc.) that you are currently taking.

Medication	Dose	How many times per day?

Allergies or intolerance to medications? Please list the allergen and the type of reaction:

_____

Health Maintenance and Screenings:

Cholesterol:	Date:	Findings:
Colonoscopy:	Date:	Findings:

Women only:

Mammogram:	Date:	Findings:
Pap Smear:	Date:	Findings:
Bone Density Test:	Date:	Findings:

Personal Medical History: Please check any of the following conditions that you have currently or had in the past.

X	Condition	Comments (date, treatment, etc.)
	Alcohol/Drug Abuse	
	Anxiety	
	Arthritis	
	Asthma	
	Bladder/Kidney Problems	
	Blood Clot (lung/leg)	
	Cancer	
	Depression	
	Diabetes (type I or type II)	
	Gastroesophageal Reflux (Heartburn)	
	Gout	
	Heart Attack or Heart Disease	
	Hepatitis (specify type)	
	High Blood Pressure	
	High Cholesterol	
	Kidney Disease/Failure	
	Kidney Stones	
	Liver Disease	
	Migraine Headaches	
	Osteoporosis	
	Pneumonia	
	Prostate enlargement	
	Sleep Apnea	
	Stroke	
	Thyroid Disorder	
	Other	

Surgical History: Please list any procedures or surgeries.
Examples include appendectomy, back surgery, breast biopsies, heart surgery, hysterectomy, etc.

Procedure	Year	Comments

Family History: If family history is known, please indicate below.

Relative	Disease/Illnesses
Mother	
Father	
Sister(s)	
Brother(s)	
Paternal Grandmother	
Paternal Grandfather	
Maternal Grandmother	
Maternal Grandfather	

Social History:

Tobacco Use

- ☐ Never (proceed to alcohol question now)
- ☐ No longer use
- ☐ Yes, currently use

Quit date:
How many years have/did you smoke(d)?
How many packs a day do/did you smoke?
Other tobacco: (please circle) Pipe Cigar Chew

Alcohol Use

Do you drink alcohol? (please circle) Yes or No
Number of drinks per week:_____

Illicit Drug Use

Do you use marijuana or other recreational drugs?
(please circle) Yes or No
Have you ever used needles to inject drugs?
(please circle) Yes or No

Females Only

When was your last menstrual period?
How many times have you been pregnant?
How many children do you have?

Safety

Is violence at home a concern for you?
(please circle) Yes or No

Sexual Activity

Sexually involved currently: (please circle) Yes or No
Sexual partner(s) is: (please circle) M or F
Birth control method:
Have you ever been treated for a sexually transmitted disease? (please circle) Yes or No

Exercise

What activity?
How long (minutes)?
How many times per week?