



<b>INSURANCE COVERAGE: Must have all insurance cards front and back.</b>		
Check all that apply: None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> Blue Chip <input type="checkbox"/> Indian Health Center <input type="checkbox"/> VA <input type="checkbox"/>		
Primary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Secondary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	

**PARTNERSHIP HEALTH CENTER  
323 WEST ALDER STREET  
MISSOULA, MT 59802**

**AUTHORIZATION AND ASSIGNMENT**

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement for Partnership Health Center (PHC).

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. Also, I authorize PHC to bill my insurance and release information to the insurance company if requested.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

FOR PHC USE: STAFF INITIALS	DATE:	SLIDING SCALE: A B C D E NONE
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**FINANCIAL STATUS WORKSHEET**

**VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)**

Family Income	Yes	No
Wages		
Self Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Food Stamps		
Child Support		
Alimony		
Other (please indicate)		

TOTAL GROSS INCOME: \_\_\_\_\_

**PARTNERSHIP HEALTH CENTER**

Patient name: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Provider Initials/Date

**ANNUAL ADOLESCENT HEALTH HISTORY**

**CURRENT MEDICATIONS:** \_\_\_\_\_

**MEDICATION ALLERGIES:**

Have you been hospitalized in the past year? Yes \_\_\_ No \_\_\_

If yes, when and for what? \_\_\_\_\_

Have you been injured in the past year? Yes \_\_\_ No \_\_\_

If yes, how and when? \_\_\_\_\_

In the past year, have you experienced any problems with your: (Please Circle)

Head	Nose	Lungs	Arms/Legs	Joints
Eyes	Throat	Genitals	Back	Muscles.
Ears	Heart	Abdomen	Skin	

Please explain: \_\_\_\_\_

Do you smoke or chew tobacco? Yes \_\_\_ No \_\_\_

# Packs/Cans Per Day \_\_\_ #Years \_\_\_

Alcohol Use? Yes \_\_\_ No \_\_\_

Amount per day \_\_\_ #Years \_\_\_

Marijuana or drug use? Yes \_\_\_ No \_\_\_

Amount per day \_\_\_ #Years \_\_\_

Do you use your seat belt regularly? Yes \_\_\_ No \_\_\_

Do you exercise regularly? Yes \_\_\_ No \_\_\_

Do you brush your teeth? Yes \_\_\_ No \_\_\_

Do you floss your teeth? Yes \_\_\_ No \_\_\_

When was your last dental visit? \_\_\_\_\_

Have you had sex? Yes \_\_\_ No \_\_\_

Are you using birth control? Yes \_\_\_ No \_\_\_

Have you had an annual exam within the past year? Yes \_\_\_ No \_\_\_

Do you use condoms to protect yourself from HIV and Sexually Transmitted Diseases? Yes \_\_\_ No \_\_\_

Have you noticed any change in your sleeping habits, appetite, energy level, or mood? Yes \_\_\_ No \_\_\_

Is there anything you would like to discuss today? \_\_\_\_\_