

INSURANCE COVERAGE: Must have all insurance cards front and back.		
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: _____

HEALTH HISTORY

PAST HEALTH PROBLEMS

Please indicate if you have experienced any of the following health problems

<u>Illness</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Glaucoma	_____	_____	Hemorrhoids	_____	_____
Cataracts	_____	_____	Kidney or Bladder	_____	_____
Ear Trouble	_____	_____	Prostrate	_____	_____
Deafness	_____	_____	Headaches/Migraines	_____	_____
Thyroid Trouble	_____	_____	Head Injury	_____	_____
Bronchitis	_____	_____	Stroke	_____	_____
Emphysema	_____	_____	Convulsions/Seizures	_____	_____
Pneumonia	_____	_____	Arthritis	_____	_____
Hay Fever	_____	_____	Gout	_____	_____
Asthma	_____	_____	Psoriasis	_____	_____
Tuberculosis	_____	_____	Eczema	_____	_____
High Blood Pressure	_____	_____	Cancer/Tumor	_____	_____
Heart Attack	_____	_____	Anemia	_____	_____
Hardening of Arteries	_____	_____	Bleeding Tendency	_____	_____
Heart Murmurs	_____	_____	Blood Transfusion	_____	_____
High Cholesterol	_____	_____	Diabetes	_____	_____
Ulcer	_____	_____	Polio	_____	_____
Bowel Problems	_____	_____	Depression	_____	_____
Hepatitis	_____	_____	Dental Problems	_____	_____
Gall Bladder	_____	_____	OTHER _____		
Mental Health Problems	_____	_____	_____		
Alcoholism/Drug Problems	_____	_____	_____		

MEDICATIONS: -

MEDICATION ALLERGIES:

HEALTH BEHAVIORS

Tobacco Use? Yes ___ No ___
 # Packs Per Day ___
 # Years ___

Alcohol/Drug Use? Yes ___ No ___
 Amount Per Day ___
 Days Per Week ___

Do you use your seatbelt regularly?
 Yes ___ No ___

Do you exercise regularly
 Yes ___ No ___

Do you brush your teeth? Yes ___ No ___ Floss your teeth? Yes ___ No ___ Last Dental Visit

HOSPITALIZATIONS/SURGERIES

<u>Year</u>	<u>Reason</u>	<u>Hospital and City</u>

HEALTH PROBLEMS IN THE LAST YEAR (Check YES or NO if known. Leave blank if unknown.)

GENERAL	YES	NO	GENERAL	YES	NO
Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Blood in vomit	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps while walking	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by heat or cold	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Breathless at night	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Breathless with walking	<input type="checkbox"/>	<input type="checkbox"/>	Occasionally lose urine and get wet	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations / irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Pass urine more than twice at night	<input type="checkbox"/>	<input type="checkbox"/>
Change in sleep	<input type="checkbox"/>	<input type="checkbox"/>	Problems with memory	<input type="checkbox"/>	<input type="checkbox"/>
Change in walking	<input type="checkbox"/>	<input type="checkbox"/>	Shaking or trembling in hands	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain / discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (rash, itch)	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sleeps sitting up	<input type="checkbox"/>	<input type="checkbox"/>
Cough / phlegm most days	<input type="checkbox"/>	<input type="checkbox"/>	Soiling from bowels	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
Decreased energy	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs / feet	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection history	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Visual Loss	<input type="checkbox"/>	<input type="checkbox"/>
Easily Bleeds / bruises	<input type="checkbox"/>	<input type="checkbox"/>	Weakness on one side of body	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or passing out	<input type="checkbox"/>	<input type="checkbox"/>	Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Falls	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HEALTH HISTORY

Have any **immediate** family members had any of the following illnesses? If so, please indicate relationship (mother, father, sister, grandparents, children)

<u>Illness</u>	<u>Family Members</u>	<u>Illness</u>	<u>Family Members</u>
High Blood Pressure	_____	Epilepsy	_____
Heart Disease	_____	Rheumatoid Arthritis	_____
Stroke	_____	Gallbladder Disease	_____
Cancer	_____	Colitis/Irritable Bowel	_____
Diabetes	_____	Migraine Headaches	_____
Asthma/Emphysema	_____	Mental Health Problems	_____
Tuberculosis	_____	Depression	_____
Cystic Fibrosis	_____	Suicide	_____
Blood Disease	_____	Alcoholism	_____
Multiple Sclerosis	_____	Other	_____

PARTNERSHIP HEALTH CENTER

Patient name: _____
Date: _____

_____ _____ Provider Initials/Date
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ANNUAL GERIATRIC HEALTH HISTORY

Please circle any of the following health problems you have experienced **within the past year**.

- | | | | |
|-------------------|-----------------|-------------------|-----------------|
| Arthritis | Bowel Problems | Convulsions | Pneumonia |
| Asthma | Anxiety | Glaucoma | Polio |
| Bleeding Tendency | Depression | Hemorrhoids | Psoriasis |
| Heart Murmur | Mental Health | Cataracts | Tuberculosis |
| Blood Transfusion | Hepatitis | Gout | Eczema |
| High Cholesterol | Deafness | Hay Fever | Seizures |
| Diabetes | Headaches | Kidney or bladder | Stroke |
| Blood Pressure | Dental Problems | Ear trouble | Thyroid Trouble |
| Cancer/Tumor | Gall Bladder | Prostrate | Head Injury |
| Heart attack | Drug Problems. | Alcoholism | Bronchitis |
| Anemia | Emphysema | Migraines | Ulcer |

OTHER: _____

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

Please explain: _____

Have you had a pneumonia or flu shot recently? Yes ___ No ___
 Do you smoke or chew tobacco? Yes ___ No ___
 # Packs/Cans Per Day _____

Alcohol/Drug Use? Yes ___ No ___
 Amount per day _____ #Years _____

Can you perform daily tasks without difficulties? (Cooking, bathing, dressing, shopping) Yes ___ No ___
 Are you still driving? Yes ___ No ___
 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 ___
 Last dental visit? _____

Are you interested in receiving an Advance Directive (Living Will) today? Yes ___ No ___