

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	_____

MALE SEXUAL HEALTH INFORMATION

	YES	NO
Do you have symptoms of penile discharge, burning with urination, itching or testicular pain?		
Do you use condoms for STD prevention?		
Do you have a rash or sores on sexual organs?		
Do you have painful intercourse?		
Have you ever had chlamydia, gonorrhea, syphilis, herpes, or genital warts?		
Do you examine your testicles monthly?		

Number of sexual partners in the last year: _____

Current Method of Birth Control:

- _____ Foam
- _____ Condoms
- _____ Partner has IUD
- _____ Partner has diaphragm
- _____ Partner is on Pill
- _____ None
- _____ Not applicable, I have a vasectomy.
- _____ Not applicable, my partner has had tubal ligation.
- _____ Not applicable, my partner has had hysterectomy.
- _____ Not applicable, I am not sexually active.
- _____ Would you like information regarding sexually transmitted diseases or HIV?

Other: