ST. JOSEPH CLINICS

NEW PATIENT PRIMARY CARE FORM

DATE: _____

Patient Information (as it appears on insurance card)

Patient Name _____ Date of Birth ____/____/_____ Male ☐ Female ☐

Mailing Address _____ City _____ State _____ Zip _____

Phone # _____ Phone Type _____ Alt Phone # _____ Phone Type _____

Email _____ Social Security # _____

Other Last Name(s) Used _____ Preferred Language _____

Race ☐ African American ☐ Alaska Native ☐ American Indian ☐ Caucasian ☐ Hispanic or Latino ☐ Native American ☐ Other _____

Guarantor (Full Name) _____ Guarantor Date of Birth ____/____/_____

Emergency Contact Information

Name _____ Phone # _____ Phone Type _____

Relationship to Patient _____

Insurance Information

Primary Insurance _____ Subscriber Name _____

Policy/ID # _____ Group # _____ Phone # _____ Phone Type _____

Secondary Insurance _____ Subscriber Name _____ Date of Birth ____/____/_____

Policy/ID # _____ Group # _____ Phone # _____ Phone Type _____

Employer Information

Employer Name _____ Phone # _____ Phone Type _____

Address _____ City _____ State _____ Zip _____ ❑ Full-time ❑ Part-time

Reason for Visit/Establishing Care - Current/Past Medical Problems

Accident Related? ☐ Yes ☐ No Previous Primary Care Provider _____ Date Last Seen _____

How often do you go to the doctor in a year? _____ Do you have any family members that see one of our providers? ☐ Yes ☐ No

Who recommended you to our clinic or how did you hear about us? _____

Allergies - Please list any allergy or intolerance you have to medications or environment (i.e. dust, nuts, animals)

Medication or Environmental Issue	Reaction

Current Medications - Include all prescription and non-prescription (over-the-counter) medications

Medication Name	Dose (mg, mcg, %)	How Often?

If you are not currently taking any medications (prescription or over-the-counter), check here ☐

Patient Name _____ Date ___/___/_____

Past Medical History

Women: Age when menses began _____ If post-menopausal, when was your last period? _____
At what age did you have your first child? _____ Total number of pregnancies _____ Miscarriages? _____

Health Conditions/Concerns

Past Surgeries/Procedures - List Type

	Year

Where were your previous vaccines or immunizations completed?

Family History - List which relative (i.e. mother, father, brother, sister, aunt, uncle, maternal/paternal grandparent, etc.)

Illness	Family Members (please list)	If grandparent, maternal or paternal?
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		

Social History

Marital Status (please choose) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Do you use tobacco products? ☐ Yes ☐ No Frequency? _____ Did you use tobacco products in the past? ☐ Yes ☐ No
Type of tobacco products ☐ Cigarette ☐ Vape ☐ Smokeless ☐ Chewing tobacco
How many years did you use tobacco products? _____ When did you quit using tobacco products? _____
Do you drink alcohol? ☐ Yes ☐ No How much/frequency? _____
Do you use recreational drugs? ☐ Yes ☐ No Type _____ How much/frequency? _____

My Health Portal

My Health Portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. Using a secure username and password, patients can view health information such as, recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results, upcoming radiology appointments, and more.

Pharmacy Preference

Pharmacy Name _____ City _____ State _____

Patient Name _____ Date ____/____/_____

Additional Comments: _____

OPTIONS FOR PAPERWORK SUBMMISSION:

1) **DROP BOX:** 222 Southway Ave., Suite B, Lewiston, ID 83501
2) **MAIL TO**: 625 6th ave, Lewiston, ID 83501
3) **FAX:** 208.750.7219
4) **E-MAIL:** clinics@sjrmc.org

QUESTIONS? CALL: 208-750-7355

Visit us online at:
sjclinics.org

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