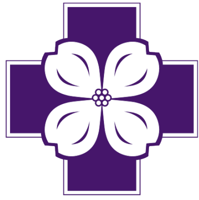

ST. JOSEPH CLINICS

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 ❑

Past Medical History

Have you had a colonoscopy? ❑ Yes ❑ No If yes, when? ____________________ Providers Name ________________________

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? ___________

Have you had any of the following? (list type if requested)	Yes	No	Date Issue Began
Acid Reflux			
Anemia			
Anxiety			
Arthritis			
Asthma			
Bleeding Tendency			
Blood Clots			
Blood Disorder - Type?			
Bowel Disease - Type?			
Cancer - Type?			
Chronic Muscle Pain			
Daytime Sleepiness			
Depression			
Diabetes - Type?			
Gallbladder Problems			
Gout			
Heart Trouble			
Hepatitis - Type?			
Hereditary Defect - Type?			
High Blood Pressure			
High Cholesterol			
Insomnia			
Joint Pain			
Kidney Failure			
Kidney Stones			
Liver Disease			
Lung Problems - Type?			
Migraines			
Osteoporosis			
Pancreatitis			
Rheumatic Fever			
Seizures			
Sexually Transmitted Disease - Type?			
Stomach Ulcers			
Stroke			
Substance Abuse Disorder - Type?			
Thyroid Gland Trouble			
Tuberculosis (TB) - Exposure or Contracted?			
Ulcers - Type?			
Other - Please Describe:			

Additional Medical Issues	Year Issue Began

Past Surgeries - List Type of Surgery	Year

Immunization History - Do not fill out unless you have specific dates	Month/Day/Year
Pneumovax (Pneumonia Vaccine)	
Zostavax (Shingles Vaccine)	
Tetanus	
PPD (Tuberculin Skin Test)	
Hepatitis A	
Hepatitis B	
Meningococcal	
MMR (Measles, Mumps, Rubella Vaccine)	
Varicella (Chickenpox Vaccine)	
Other - Please List:	

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?
Arthritis		
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		
Heart Attack		
Migraines		
Seizures		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		

Social History

Marital Status (please choose) ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Do you smoke? ❑ Yes ❑ No Frequency? ____________ Did you smoke in the past? ❑ Yes ❑ No

How many years did you smoke? __________________________ When did you quit smoking? ____________________________

Do you use smokeless tobacco? ❑ Yes ❑ No Frequency? __________ Did you use smokeless tobacco in the past? ❑ Yes ❑ No

How many years did you use smokeless tobacco? _____________ When did you quit using smokeless tobacco? _________________

Do you drink alcohol? ❑ Yes ❑ No How much/frequency? ____

Do you smoke marijuana? ❑ 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.

Have you signed up for My Health Portal? ❑ Yes ❑ No If no, please check here if you would like to sign-up ❑

Pharmacy Preference

Pharmacy Name ____

Pharmacy Address ____ City ___________________ State _____ Zip __________

Pharmacy Phone # ____________________________________ Pharmacy Fax # ______________________________________

Additional Comments: ____

____

____

____

____

DROP BOX: 222 Southway Ave., Suite B, Lewiston, ID 83501
MAILING ADDRESS: 504 6th Street, Lewiston, ID 83501
FAX: 208.750.7219
QUESTIONS? CALL: 208.750.7355

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