



# 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, age at 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**

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: \_\_\_\_\_

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**OPTIONS FOR PAPERWORK SUBMISSION:**

- 1) **DROP BOX:** 222 Southway Ave., Suite B,  
Lewiston, ID 83501
- 2) **MAIL TO:** 415 6th St, Lewiston, ID 83501
- 3) **FAX:** 208.743.0118

**QUESTIONS? CALL:** 208-750-7355

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