Senior Care Northwest
New Patient Forms

Community:____

Patient Name:_________________________________DOB: _______/_______/_______SSN:____________________________

Phone Number:___________________________________Ethnicity:_________________Language:_____________________

Address:____Apt. #:___________________

City/Zip:____

Insurance Information: (**please attach photocopies of both sides of cards**).

Primary Insurance:____

ID Number: ____________________________________Group Number:_____________________________________

Phone number on back of card:____

Secondary Insurance:____

ID Number:_____________________________________Group Number:_____________________________________

Phone number on back of card:____

Medical/Billing Representative/POA/Emergency Contact:

Name:____

Address: ____

Phone Number:____Relationship:________________________________

Past Medical History: Please circle any that apply to you.

Alzheimer's disease	Vascular dementia	Other forms of dementia
High blood pressure	Kidney disease	Heart failure
Heart Disease	Heart Attack	Atrial fibrillation
Blood thinners	Major bleeding	Blood Clots
Stroke	Problems from a stroke	Depression
Anxiety	Mental Illness	Behavioral problem
Frequent Falls	Pneumonia	Lung problems
COPD	Asthma	Urinary/Bladder infection

Allergies:____

Other:____

List any surgeries/dates:

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Social history:

Married/ Divorced/ Widowed/ Single Number of children:____________________

History of smoking or current smoker?______________________________

Occupation? When did the patient retire?______________________________

Any alcohol use?____________________ Walker/ Wheelchair/ Cane

What concerns do you have for the provider?

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Important information ***Please read and sign below***

It is the patient or responsible party's responsibility to know the insurance policies and see that we obtain any necessary referrals prior to the visit. You are responsible for any co-pays, deductibles, or any expense that your insurance does not cover. It is the patient or responsible party's responsibility to provide accurate and current insurance information prior to each visit, we cannot retroactively bill insurance for past service dates. For some patients we bill for Chronic Care Management services. This allows us to capture time we spend on these patients outside of appointments. This is a medicare service covered by most insurance plans, but may be subject to co-pay. You may opt out of this service at any time.

Name of Person completing this form:______________________________

Relationship to patient: ________________________________

Signature______________________________Date______________