New Patient Intake Forms

Patient Information

Full Name: _____
DOB: _____ / _____ / _____ **Community:** _____
Phone: _____ **SSN:** _____
Primary Language: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Number of Children:**_____

Emergency Contact & Insurance (*Please provide copies of insurance cards*)

Emergency Contact: _____
Phone: _____ **Relationship to Patient:** _____
Attends Appointments? Y / N **| Statement Recipient?** Y / N **| Power of Attorney?** Y / N
Patient Billing Address: _____
_____
Primary Insurance: _____ **Policy #:** _____
Secondary Insurance (if any): _____ **Policy #:** _____
Preferred Pharmacy: _____ **Location:** _____

Allergies & Conditions (*Check the boxes*)

☐ No Known Allergies ☐ Medication Allergies: _____
☐ Food/Other Allergies: _____

☐ Alzheimer's/Dementia ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke
☐ Smoker (Former / Current) ☐ Atrial Fibrillation ☐ Frequent Falls ☐ UTIs ☐ COPD / Asthma
☐ Kidney Disease ☐ Cancer (Type: _____) ☐ Depression / Anxiety
☐ Chronic Pain ☐ Current Opiate Use ☐ Current Alcohol Use (Drinks per week:_____)
☐ Other: _____

Past Surgeries & Dates: _____
_____
_____

Falls in Past Year? ☐ No ☐ Yes / ☐ With Injury? ☐ Assistive Device (Walker/Cane/WC)

Advance Directives

☐ Living Will ☐ Power of Attorney ☐ POLST (DNR / CPR) ☐ None

What concerns do you have for the provider?: _____
_____
_____
_____
_____
_____

Financial Responsibility & Clinic Policies

I acknowledge that it is the patient or responsible party's responsibility to know the insurance policies and see that they obtain any necessary referrals prior to the visit. They are responsible for any co-pays, deductibles, or any expense that their insurance does not cover. It is the patient or responsible party's responsibility to provide accurate and current insurance information prior to each visit, Senior Care Northwest cannot retroactively bill insurance for past service dates. For some patients Senior Care Northwest bills for chronic care management services which allows us to perform care plan maintenance outside of appointments. This is a Medicare service covered by insurance but may be subject to co-pay. You may opt out of this service at any time. A copy of the care plan is available upon request. If the patient resides in a care facility that we service and subsequently moves out they will need to establish care with a new PCP upon move out.

I certify that the information provided on this form is correct. I authorize the release of medical information needed to process claims and request direct payment to the provider for services rendered.

Patient/Responsible Party Name (Print): _____

Signature: _____

Date: _____ / _____ / _____

Senior Care Northwest/Forest Grove Geriatrics
Medical Records Release Form

PO Box 3294 Hillsboro, OR 97124
Ph: (503) 372-6277 Fax: (503) 716-4714

Dear, medical provider. Your client requests that their medical records from the past three years be sent to our practice.

Previous PCP or Clinic name:_____

Previous PCP Phone number: _____

Client Name: _____

Telephone: _____ Email: _____

DOB: _____

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment.

Company: Senior Care Northwest

Address: PO Box 3294

City: Hillsboro

State: Oregon Zip code: 97124

Telephone: 503-372-6277 Fax: 503-716-4714

Client Signature: _____

Date: _____

SENIOR CARE NORTHWEST, LLC
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Senior Care Northwest (SCNW) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SCNW reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Josh Agee at SCNW.

With my consent, SCNW may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, SCNW may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements.

With my consent, SCNW may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that SCNW restrict how it uses or discloses my PHI to carry out treatment, payment and healthcare operations. This practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to SCNW use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it SCNW may decline to provide treatment to me.

Signed by: _____ _____

Print Patient's Name | Print name of Legal Guardian; if applicable

_____

Relationship to Patient

_____ _____

Signature of Patient or Legal Guardian | Date

Patient/Guardian must be offered a signed copy of this authorization form