Patient Information

Sellwood Family Medicine LLC

1567 SE Tacoma Street, Portland, OR, 97202 ☎ 503.233.8113

Today's date: _____/_____/_____

PATIENT'S INFORMATION

Name:_____ Date of Birth _____
Last First M.I.

Home Address:_____
Street Address Apt # City State Zip Code

Email (for our use only) _____ Home Phone: _____ Cell phone:_____

PARENT'S EMPLOYER INFORMATION

Employer's Name: _____
Employer's Address: _____
_____

Employment Status (circle):
not employed / full time / part time / retired

Work phone: Driver's

Were you referred to this clinic? yes / no
If so, by whom? _____

If not, how did you hear about us?
_____

In case of an emergency, whom should we contact? Name:
_____
Phone: _____
Relationship: _____

INSURANCE INFORMATION

Insurance Company Name:_____
Insurance Company Address: _____
Street Address City State Zip Code

Policy Holder Name: _____ Relationship to you: self/spouse/child/other

Policy Holder employer: _____ Policy Holder's date of birth: ____/_____/_____

Secondary Insurance Company Name:_____
Insurance Company Address: _____
Street Address City State Zip Code

Policy Holder Name:_____Relationship to you: self/spouse/child/other

Policy Holder employer: _____ Policy Holder's date of birth: _____/_____/_____

Your marital status: _____ Your Student status: non student / full time / part time

FINANCIAL POLICY

We are committed to providing you with the best possible medical care at the lowest possible cost. Prompt payment allows us to control costs, which ultimately keeps our fees to a minimum. The following is a statement of our financial policy that we require you to read and sign prior to your first treatment:

Payment in full is due at the time of service. We accept credit cards, cash and checks. Our practice participates with most insurance carriers and, as a courtesy to patients, we will file claims directly with the respective insurance company. At the time of service, we require payment for any non-covered services, standard co-pay, and coinsurance. Patients whose co-insurance is based upon a percentage of the charge should pay their designated percentage of the bill at the time of service. If you have a deductible that has not been met, your insurance carrier will apply fees for today's services to that deductible. We ask that you pay upfront for today's fees.

Patients are responsible for obtaining the necessary referral form, if their insurance company requires one. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowance for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates that may bear no relationship to the current standard and cost of care in this area.

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Unless we are notified at least 24 hours in advance, our policy is to charge for missed appointments.

Our practice believes that a good doctor-patient relationship is based upon effective communications. If you have any questions, please feel welcome to contact us at 503-233-8113.

By signing below I agree that I have read and understand this policy.

SIGNATURE: _____ **DATE:** _____

Sellwood Family Medicine, LLC

1567 SE Tacoma St. Portland, OR 97202
Tel:(503) 233-8113 Fax: (503) 239-8937

Consent to Treatment of A Minor

I, being the parent/ guardian of _____, a minor, the age of _____ do hereby consent, authorize and request Dr. Leigh Ann Chapman or Dr. Patrick Chapman to administer such treatment deemed advisable, necessary or requested on the above minor.

Signed _____ Date _____
(Parent or Guardian)

Patient Health History

Mother's Name:_____ Fathers Name:_____

Siblings (and ages):

What are your main health concerns and expectations for this visit?

Who are your main caretakers?

Who is your Primary Care Physician (PCP) and when was your last visit? Why?

Do you have any pre-existing medical conditions or diagnoses?

Do you have any allergies or sensitivities to drugs, foods, environmentals or otherwise?

Are you vaccinated up to schedule? Do you need more information about vaccination?

What are the major stressors in your life?

When and where have you traveled outside of the country?

Are you taking any medications?

Medication	Dose	Frequency	Reason/ condition

Are you taking any supplements, vitamins or herbs?

Supplement	Dose	Frequency	Reason/ condition

Diet/ Nutrition:

Were you breast fed? Yes/ No If so, for how long? _____

If formula fed, what kind (soy, dairy, nutramagen, etc.) _____

What is your diet like? (Typical breakfast, lunch dinner and snack) Food Cravings?

What kind of pets do you have? (indoor and outdoor)

Do you have a faith/ spirituality and how important is it in your family's life?

What are your favorite toys/ hobbies/ interests?

Are there other things I should know about you?