North Olympic Healthcare NETWORK

North Olympic Healthcare Network
240 West Front Street | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

NEW PATIENT REGISTRATION - ADULT

PATIENT INFORMATION

First Name _____

Last Name _____

Identifying Gender Male ☐ Female ☐ Social Security # _____

Date of Birth _____ Contact Phone # _____

Address _____

City _____ State _____ Zip _____

Emergency Contact Name _____

Contact Phone # _____ Relationship _____

FEES AND BILLING

No patient will be denied service due to inability to pay. We offer a Sliding Fee Discount program which can provide discount fees for certain services. To see if you qualify please complete the information below.

Gross Monthly Household Income $ _____

Number of Family Members in Your Household _____

I decline to see if I qualify for Sliding Fee Discount ☐

PATIENT NAME _____ **DATE OF BIRTH** _____

ASSISTANCE

Does the patient need a language interpreter for appointments? ☐ Yes ☐ No

Does the patient need a sign language interpreter for appointments? ☐ Yes ☐ No

Does the patient need help with transportation assistance to appointments? ☐ Yes ☐ No

INSURANCE INFORMATION

Do you have health insurance? Yes ☐ No ☐
If no, would you like information on signing up for health insurance? Yes ☐ No☐

Insurance Name _____

Policy Number _____Group Number _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber relationship to patient _____

Do you have a secondary insurance? Yes ☐ No ☐

Insurance Name _____

Policy Number _____Group Number _____

Subscriber Name _____Subscriber Date of Birth _____

Subscriber relationship to patient _____

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NORTH OLYMPIC HEALTHCAR NETWORK
HEALTH QUESTIONNAIRE

DATE**:** _____ NAME (PRINT): _____

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐ **M** ☐ **F** SEX AT BIRTH ☐ **M** ☐ **F**

HEALTH HISTORY: (*Circle and/or fill in***)**

Major Illnesses: None Diabetes High Blood Pressure Heart Trouble Cancer Arthritis
Seasonal Allergies Other _____

Major Surgeries: None Tonsils Appendix Hernia Gallbladder Hysterectomy
Other _____

Major Injuries: None Broken Bones Head Injuries
Other _____

Pregnancies: ☐ NO ☐YES
Number vaginal deliveries: _____ Number cesarean deliveries: _____
Number of miscarriages: _____ Date(s): _____

Social: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Number of children and ages: _____
Tobacco: ☐ NO ☐ YES **Type**: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew
Alcohol: ☐ NO ☐ YES # of drinks per day _____ week _____ month _____
Occupation: _____
Were you born outside the USA? ☐ NO ☐YES If yes, where? _____

Immunizations: *Date last received (if known)*
Tetanus _____ Flu _____Hep B _____ Shingles _____Pneumonia_____

Annual Care: *Date of last screening (if known)*
Pap Smear _____ Mammogram _____ Colonoscopy _____

MEDICATION HISTORY: List **ALL** medications you take every day (*prescribed and over the counter*):
_____
_____

List any **DRUG** allergies you have: _____

FAMILY HISTORY: Check the box(s) of anyone in your immediate family who has or had any of the following:

Heart Disease: ☐ Parent ☐ Sibling ☐ Child
High Cholesterol: ☐ Parent ☐ Sibling ☐ Child
High Blood Pressure: ☐ Parent ☐ Sibling ☐ Child
Stroke: ☐ Parent ☐ Sibling ☐ Child
Diabetes: ☐ Parent ☐ Sibling ☐ Child

Mental Illness: ☐ Parent ☐ Sibling ☐ Child
Breast Cancer: ☐ Parent ☐ Sibling ☐ Child
Colon Cancer: ☐ Parent ☐ Sibling ☐ Child
Prostate Cancer: ☐ Parent ☐ Sibling ☐ Child
Ovarian/Uterine or Cervical: ☐ Parent ☐ Sibling ☐ Child

Anything else you would like to share regarding your health history? _____
_____
_____