New Patient Intake Form

Please answer ALL questions as accurately as possible. Thank you!

Patient Information

First Name (PRINT) MI Last Name (PRINT)

Birthdate (MM/DD/YYYY) Gender:_____ SSN

Preferred Pronouns:_____ Sexual Identity:_____ Preferred Name

Contact Information

Cell Phone # Email

Home Phone #

How do you prefer we contact you? cell # home # email

Street Address Apt

City State & Zip

Payment Information

Health Insurance (check ALL that apply)

- ☐ Medicare A only
- ☐ Medicare A & B
- ☐ Medicare D
- ☐ I have additional Medicare coverage.
- ☐ Medicaid/Apple (choose one): Molina United Healthcare Amerigroup
- ☐ Veterans' Insurance
- ☐ No Insurance
- ☐ Other _____

Please give the receptionist your insurance card(s) and ID so that we may have a copy on file.

Emergency Contact Information

Contact This Person in an Emergency Relationship to Patient

Phone #

Demographics

Ethnicity

- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other _____

Medical History

Preventive Care

Exercise? Yes / No How often? _____

Nutrition/Common Foods: _____

Smoking?	Yes / No	E-cigs?	Yes / No	Packs per day:
Alcohol?	Yes / No	Number of drinks per week?		
Recreational Drugs or Marijuana			Yes / No	How Often?
Have you ever tried recreational drugs or marijana in the past?				Yes / No

Allergies

☐ No allergies of any kind

drug allergies	environmental allergies	food allergies

Medications

Please bring in a list of medications if you have more than 4.

Medication Name	Dose	How often?	Need refills soon?

Pharmacy

Which pharmacy do you use? _____

Please ask your pharmacy to fax OPCC a complete list of medications.

Social Health

Income	
Do you have a job?	Yes / No
How much money do you (and your spouse if you are married) make before taxes?	$
How many children under age 18 do you support (on your taxes)?	
Are you legally disabled with disability insurance?	Yes / No

Housing and Food	
Are you homeless?	Yes / No
Are you at risk for homelessness?	Yes / No
Do you need help finding housing?	Yes / No
Have your utilities (water, heat, electricity) been shut off?	Yes / No
Do you need help paying for food?	Yes / No

Medical	
Would you have gone to the Emergency Room if OPCC was not here?	Yes / No
Do you visit another doctor?	Yes / No
When was your last medical or dental appointment?	
Have you ever been treated by a mental health professional?	Yes / No
Have you been told by a doctor that you have diabetes?	Yes / No
Do you have a family member with diabetes?	Yes / No
Have you been told by a doctor that you are overweight?	Yes / No
Are you less than 65 years of age, and get little or no exercise daily?	Yes / No
Is there any history of cancer in your family? If so, please specify who.	Yes / No

Dental	
Do you have tooth or mouth pain?	Yes / No
Have you taken Antibiotics for tooth infections?	Yes/No
When was your last cleaning?	

I have read this packet, or it has been read to me, and I have provided accurate information to the best of my knowledge.

Signature _____ Date _____

Olympic Peninsula Community Clinic (OPCC) does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities.

2024 VERIFICATION OF QUALIFICATION FOR FINANCIAL ASSISTANCE

I verify that I qualify for financial assistance based on the information provided in the chart below. This chart is the current (2024) Federal Poverty Guidelines multiplied by a factor of 2 per OMC's Financial Assistance policy.

It is my understanding that Olympic Medical Center has an agreement with Olympic Peninsula Community Clinic (OPCC) in Port Angeles to provide diagnostic imaging and lab services at no charge to OPCC patients who meet the financial assistance guidelines stated in the chart below – which is based on the 2024 Federal Poverty Guidelines.

I (printed name), _____ verify that I qualify for financial assistance based on the number of members in my household and my monthly/annual household income, as checked below.

2024 Persons in family/household	Two times the Poverty guideline Income Level
1	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680
8	$105,440
For families/households with more than 8 persons, add $5,380.00 for each additional person.	

Patient Name Printed: _____

_____ _____

Patient Signature Date

RE dis COVERY

BCHP Screening Sheet

Do you qualify for free mammograms, or pap exams?

Olympic Peninsula Community Clinic (OPCC) is offering a special program to patients without insurance and who are between the ages of 40 and 64.
You may qualify for free mammograms and/or Pap exams.
Please fill out this form to help us determine if you qualify.

Women Only:

First Name (PRINT) _____ Last Name (PRINT) _____

Birthdate (MM/DD/YYYY) _____ Phone # _____

How do you prefer we contact you? cell # text home #

Do you have insurance? Yes / No Type: _____

When was your last Pap Exam?

When was your last Mammogram?

For All Patients

Have you ever done a Stool Sample Kit? Yes / No If yes, when?

Have you ever had a Colonoscopy? Yes / No If yes, when?

Authorization to Disclose Protected Health Information

Olympic Peninsula Community Clinic
Phone: 360-457-4431 **Fax**: 360-457-7755

Patient Information:
Patient Name (Printed):_____

Previous Name(s):_____

Date of Birth: _____ Daytime Telephone Number:_____

SEND INFORMATION TO: (Please be Specific)
Provider Name/Organization: **OLYMPIC PENINSULA COMMUNITY CLINIC**
Address: **819 GEORGIANA ST / P.O. BOX 639**
City: **Port Angeles** State: **WA** Zip Code: **98362**
Medical Phone: **360-457-4431** Fax: **360-457-7755** Dental Phone: **360-477-4120**

INFORMATION TO BE RELEASED FROM: (Please be specific)
Provider Name/Organization:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Fax Number_____

PURPOSE OF DISCLOSURE
○Transfer of Care ○Self ○Specialist ○Other_____

INFORMATION TO BE DISCLOSED
○Medical Information from the last two years
○Limited Health Information of Documentation Dates of Service: _____
○Complete Medical Chart Contents
○Other_____ Expiration Date (or event): _____

CONSENT TO DISCLOSE
If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. **This form must be dated** within 90 days of receipt and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA 1996. **If no expiration date or event is specified this form is valid for 1 year after the date of signing.**

BY SIGNING THIS RELEASE I UNDERSTAND THAT:
The provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The recipient may not be subject to Federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a patient in a Federally assisted alcohol or drug abuse program, the Recipient is prohibited under Federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the patient or as otherwise permitted under Federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2)
I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from OPCC.
I may revoke this Authorization at any time, and it will not take effect on any action taken by the provider that is reliant on this Authorization before the provider receives written notice of revocation.
A minor client's signature is required in order to release information concerning care for behavioral/mental health conditions and/or alcohol/drug use issues, and in order to release information regarding pregnancy and/or termination, sterilization and sexually transmitted diseases.

DISCLOSURES REQUIRING SPECIAL CONSENT
My signature below specifically authorizes the **exclusion** of healthcare information relating to the testing, diagnosis, or treatment for **(Please initial beside the specific information to exclude)**

_____HIV/AIDS Virus _____Mental Health/Psychiatric Disorders
_____Sexually _____Drug/Alcohol Use

_____ _____ _____
Date Signature of patient or representative Relationship to patient

VIMO Psychosocial Screener

Name: _____ Date: _____

Please circle the answer or fill in the blank. Please answer all of the questions honestly and to the best of your ability.

ANXIETY

Over the last 2 weeks, how often have you been bothered by the following problems.

	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious or on edge?	0	1	2	3
2. Not being able to stop or control worrying?	0	1	2	3
3. Worrying too much about different things?	0	1	2	3
4. Trouble relaxing?	0	1	2	3
5. Being so restless that it is hard to sit still?	0	1	2	3
6. Becoming easily annoyed or irritable?	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3

PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?	YES	NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	YES	NO
3. Were constantly on guard, watchful, or easily startled?	YES	NO
4. Felt numb or detached from others, activities, or your surroundings?	YES	NO

CONTINUE TO NEXT PAGE →→→→

DEPRESSION

Over the last 2 weeks, how often have you been bothered by any of the following problems.

	Not at all	Several days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

SUBSTANCE USE

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times a month	2–3 times a week	4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day when drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	(0)	(1)	(2)	(3)	(4)

4. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

_____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name _____ Today's Date _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

Part A	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

CHA Division on Addiction
Cambridge Health Alliance

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Brief Biosocial Gambling Screen (BBGS) Questionnaire

Name _____ Date _____

To screen for potential gambling-related problems, please ask the following questions.[1]

1. **During the past 12 months, have you become restless irritable or anxious when trying to stop/cut down on gambling?**

   - Yes
   - No

2. **During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?**

   - Yes
   - No

3. **During the past 12 months did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?**

   - Yes
   - No

[1] An online version of the BBGS is available at http://divisiononaddiction.org/wp-content/plugins/bbgs-e-screener/index.php

Time 11:15 AM | Olympic Peninsula Community Clinic | Date 8/6/2020

OPCC Health History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation in the past 2 years?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you have dental pain?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics

Other? ☐ If yes

Are you a veteran?	◯ Yes ◯ No	
Are you at risk for homelessness?	◯ Yes ◯ No	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No
Renal Dialysis	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

RE DISCOVERY

Welcome to OPCC!

Please note that almost ALL of the people you see here working at OPCC are volunteers and do not receive compensation for their time. We want you to feel cared about when you are here. Please be kind to everyone here, as each one of us is doing their best to help you stay well.

OPCC Does NOT Prescribe:
- Medical Marijuana
- Narcotics
- Mental Health Medications

Please Notify OPCC if any of the following occurs:
- Change in Pharmacy
- Change in Address
- Change in Phone Number
- Change in Insurance
- Change of Primary Care Provider

No Show/15 minutes Late Policy

1. You may be counted as a **No Show** if you:
   - Do not come in to an appointment
   - Cancel the day of an appointment
   - Leave before your appointment
   - Arrive more than 15 minutes late to an appointment

2. If you arrive more than 15 minutes late to an appointment you may need to reschedule to be seen.

3. Please call us **at least 24 hours** before your appointment time if you need to cancel.
This allows other community members to be seen by our providers if you are unable to come in.

Medication Refills

1. If you are also receiving medications somewhere other than OPCC, with the exception of a prescription written from an Emergency Room visit, we may discontinue refills for your medications.

2. When picking up a last refill on a medication, please ask your pharmacy to send us a refill request and call us to schedule an appointment.

If you have not been seen in a year or longer, OPCC will withhold refilling prescriptions until you make an appointment with us. You will be notified once we receive a refill request from your pharmacy and the provider has informed us that he would like to see you. **Failure to make or come to this appointment may result in further delay of your medications.**

OPCC does not charge fees for office visits, however, we ask that patients donate as they are able. Also, many diagnostic tests, outside procedures, and referrals are NOT free. It is your responsibility to inquire ahead of time about fees.

By signing this form, you acknowledge that you have read and understand the above and agree to notify OPCC of any changes listed above.

_____ _____

SIGNATURE DATE

Notice of Privacy Practices

Your Rights

Get a paper copy of your medical record, and a copy of this privacy notice. Ask us to see or get a copy or summary of your health information. You can also ask for a copy of this privacy notice. We will provide you with a paper copy promptly.

Ask us to correct your medical record. You can ask us to correct health information that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us *not* to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority before we take any action.

File a complaint if you feel your rights are violated. You can complain to us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes or sale of your information
- Most sharing of psychotherapy notes.

Our Uses and Disclosures

We typically use or share your health information to:

Treat you. We can use your health information and share it with other professionals who are treating you.

Run our organization. We can use or share your information to run our practice, improve your care, and contact you when necessary.

Bill for your services. We can use or share your information to bill and get payment from health plans.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues. We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director, when an individual dies.

Address government requests. We can use or share health information about you:

- For workers' compensation.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to **maintain the privacy and security** of your protected health information.

We **will let you know promptly if a breach occurs** that may have compromised the privacy or security of your information.

We must **follow the privacy practices described** in this notice and give you a copy of it.

We will **not use or share your information other than as described here** unless you tell us we can in writing. We you tell us we can, you can let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We **can change the terms of this notice,** and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.

I have received and read OPCC's Notice of Privacy Practices.

Signature _____ Date _____