Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

11900 SW Greenburg Road
Tigard, OR 97223
Phone: 503.620.5556
Fax: 503.624.0118

New Patient Child Intake

Name:_____ Date:____/____/_____
Date of Birth:____/____/_____ Legal sex: ☐ Male ☐ Female

GENERAL

1. Where was the child born? _____
2. What was their birth weight? _____
3. Were there any problems during the pregnancy? ☐ Yes ☐ No
4. Was the child born at term (on-time)? ☐ Yes ☐ No
5. When was the last time the child was **seen by a primary care provider**? _____
   Who did they see?_____
6. Do you think the child is up to date on immunizations? ☐ Yes ☐ No
7. Has the child ever been hospitalized? ☐ Yes ☐ No

ALLERGIES

7. Has the child ever had any **allergic reaction (bad effect)** to a medicine or shot? ☐ No ☐ Yes
   Please write the name of the medicine or shot and the effect you had: _____
8. Does the child get a significant **allergic reaction (bad effect)** from anything else? ☐ No, they have no allergies.
   ☐ Yes, please list: _____

MEDICINES

9. Please list any prescription medications or supplements that the child has been prescribed and/or are currently taking:
   ☐ No, they do not take any prescription medicines.
   ☐ Yes. List the medicines below **OR** I brought their pill bottles or a list

Medicine or Vitamin Name	Strength or Amount	How many pills or doses do you take at a time?				
EXAMPLE: Albuterol	90 mg	As needed	morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed

SURGICAL HISTORY

10. Has the child **ever** had **surgery**? ☐ No, they have never had surgery ☐ Yes. Please list each surgery below.

Surgery	Date

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MEDICAL HISTORY

11. Has the child **ever** had any of the following health problems? *Check all that apply.*

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (type: _____)
- ☐ Diabetes (high blood sugar)
- ☐ Eating disorder
- ☐ Eczema (skin problem)
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart murmur (extra noise heart makes)
- ☐ Immune deficiency
- ☐ Inflammatory bowel disease
- ☐ Jaundice (skin and eyes turn yellow)
- ☐ Kidney stones
- ☐ Meningitis
- ☐ Otitis media (recurrent ear infections)
- ☐ Pneumonia
- ☐ Prematurity (born too early)
- ☐ Scoliosis (curving of the backbone)
- ☐ Seizures
- ☐ Sickle cell (disorder affecting red blood cells)
- ☐ Strep throat (recurrent throat infection)
- ☐ Thyroid disease
- ☐ Tuberculosis (TB, lung disease)
- ☐ Urinary infections
- ☐ Varicella (chicken pox)
- ☐ Vision problem (problems seeing)
- ☐ Other: _____

FAMILY HISTORY

12. Have any of the child's **family members** ever had any of the following health problems?
Check all that apply.

	Name	Alive?	No know history	Arthritis	Asthma	Birth defects	Cancer	Depression	Heart disease	High Blood Pressure	High Cholesterol	Kidney disease	Obesity	Stroke	Substance abuse	Thyroid Disease	Other
Mother																	
Father																	
Sister																	
Sister																	
Brother																	
Brother																	
MGM																	
MGF																	
PGM																	
PGF																	

MGM = Maternal Grandmother MGF = Maternal Grandfather
PGM = Paternal Grandmother PGF = Paternal Grandfather

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SOCIAL HISTORY

13. Select all that apply.

Does anyone in the family smoke? ☐ Yes ☐ No
Does the child use community resources? ☐ Yes ☐ No
Is the child in school? ☐ Yes ☐ No Grade: _____
Are there any pets in the home? ☐ Yes ☐ No
Recent travel outside of the area? ☐ Yes ☐ No
Tobacco exposure inside the home? ☐ Yes ☐ No
Tobacco exposure outside of the home? ☐ Yes ☐ No
Is the child adopted? ☐ Yes ☐ No
Has there been a divorce or separation? ☐ Yes ☐ No
Any DHS involvement? ☐ Yes ☐ No
Is the child in foster care or in a group home? ☐ Yes ☐ No
Is either parent incarcerated? ☐ Yes ☐ No
Has the child or another child in the home been incarcerated? ☐ Yes ☐ No
Firearms in the child's home? ☐ Yes ☐ No
Who does the child live with? _____

SPECIALTY SERVICES

14. Is the child **currently** seeing any other doctors?

Doctor's Name: _____ Type of Doctor: _____
When Last Seen: _____ Phone Number: _____

Doctor's Name: _____ Type of Doctor: _____
When Last Seen: _____ Phone Number: _____

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When Last Seen: _____ Phone Number: _____

Anything else we should know?

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Release of Information

Instructions: Fill in the name of any person(s) to allow Southwest Family Physicians to discuss your medical information with them.

I, _____, with date of birth, _____, give the providers and office staff of Southwest Family Physician's permission to discuss my medical condition with the listed person(s) below. Southwest Family Physicians may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

Please **initial** the information you want disclosed:

____ Information relating to my medical treatment

____ Psychiatric disorders/Mental health

____ Alcohol/Substance abuse

____ Sexually Transmitted Diseases/HIV

____ All other health information

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Note: This authorization does NOT allow for the sharing of copies from the patient's health record. If there is an anticipated need for copies of the patient's health record, our standard form must be completed and submitted to the medical records department.

The consent will be considered valid for 2 years or until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Patient Name _____ DOB _____

Signature _____ Date _____

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Authorization to Disclose Protected Health Information

Instructions: Fill in the name of your previous practice or provider to allow Southwest Family Physicians to retrieve your medical records from them.

Patient Name: _____ Patient Phone: _____ Date of Birth: ___/___/_____

The purpose of the use/disclosure is for:
□Continuity □Transfer of care □Personal □Disability □Insurance □Legal □ Other:_____

I authorize Southwest Family Physicians to **request records from** _____
and/or release records to Southwest Family Physicians. Needed by date: _____/_____/_____

Provider/Facility Name/Individual:_____
Address (if known): _____
Phone (if known): _____ Fax (if known)**:** _____

This authorization shall begin immediately and remain in effect for not more than 180 days from this date unless another date is specified.

Please **initial** the information you want disclosed:

____ Most recent 5 year history or _____
____ Clinical chart notes
____ Prenatal / OB notes
____ Other: _____
____ Laboratory/Pathology
____ Diagnostic Imaging Reports
____ Immunizations
____ Records related to (specific dates, conditions, etc) _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

____ HIV/AIDS information
____ Genetic testing information
____ Mental health information
____ *Drug/alcohol diagnosis, treatment, or referral information

*Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care service or reimbursement for services. I understand I may revoke this authorization in writing at any time. The only exception is when information has already been released in response to this authorization.
I also understand that, in the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

Signature of Patient / Authorized Individual _____ Date _____/_____/_____

If signed by other than patient, indicate relationship: _____

DO NOT SEND MEDICAL RECORDS BY CD - WE DO NOT ACCEPT THIS FORM OF RECORDS - THANK YOU

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Prescription Policy

Since the advent of pharmacy automated prescription refills, our office receives an ever increasing volume of calls and faxes daily for medications refill requests. We cannot safely manage this volume of phone and faxed medication requests and still provide you with the quality of care you deserve.

1. Before you come to your appointment, you should look over your medications, diabetes supplies, inhalers, etc. to determine if you need to request any new prescriptions while you are here at your face to face appointment.
2. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval will vary, depending on the type of medication prescribed, how sick or stable your condition is, and what is agreed upon between you and your provider when you are here. **PLEASE BE SURE YOU HAVE ENOUGH MEDICATION TO LAST UNTIL YOUR NEXT SCHEDULED VISIT.**
3. Please bring all your prescription bottles with you to your appointment or a list including name of medication, dose, how often you take the medication, and the prescribing provider. This is important to make sure we cross-check that you are taking the correct medications and the correct doses. We will continue to take time to carefully review your medication and write enough refills at your office visit. We will also ask you to review the new prescriptions to make sure that they are written correctly.
4. We offer the following options for your in office, face to face prescription refills:
    - We can send most prescriptions electronically to most local pharmacies.
    - We can send prescriptions electronically to a mail-order pharmacy. You need to already have an account set up with the mail-order pharmacy for us to do this.
    - We can provide written prescriptions.
    - Prescriptions for certain narcotics, mental health medications, including those for attention deficit disorder medication must be printed and hand signed, as it is required by law.
5. Please plan your prescription needs in advance: prescription refill requests should not be coming to us over the phone and fax, unless there is some urgent exception. All refills will be reviewed, discussed, and refilled face to face. In the event of a rare exception, refills may take up to **2 business days.** If it is a prescription that must be hand signed and picked up at the office it may take up to **4 business days or longer**, should your provider be out of the office.
6. If you call to request a refill, but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in just enough medication to a local pharmacy to last until we are able to schedule an office visit. **IT IS YOUR RESPONSIBILITY TO SCHEDULE AN APPOINTMENT BEFORE YOU RUN OUT OF MEDICATION.**

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Prescription Policy

5. We understand that there might be a situation when you do have to call us for a prescription. Check the list below and see what you can do to avoid incurring a prescription refill fees at the pharmacy.

    - **Are you changing to a new local pharmacy?** You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. We sometimes do not have to write new prescriptions.
    - **Are you going on an extended vacation and need to use an out-of-town pharmacy?** You need to call the **NEW** pharmacy that you will be using and have them contact your hometown pharmacy to have your prescription transferred. When return home, you have to reverse the process.
    - **Are you changing to a new mail order pharmacy?** Some pharmacies will transfer prescriptions to the new pharmacy. If you still have refill on your current prescriptions, please check with your current mail order pharmacy to see if your prescriptions can be transferred.

Thank you for choosing SW Family Physicians as your provider. We look forward to working with you to assure safe and high quality medical care.

Patient Name _____DOB _____/_____/_____

Patient Signature _____ Date _____/_____/_____