WELLSPRING
FAMILY PRACTICE

Patient Registration *(please print clearly)*

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Birth Sex: ☐ Male ☐ Female

SSN: _____ Driver License #: _____ Preferred Language: _____

I identify as: ☐ Female ☐ Female-to-Male Transgender ☐ Non-Conforming
☐ Male ☐ Male-to-Female Transgender
☐ Other: _____ ☐ Decline to answer

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American
☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell Email: _____

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

Preferred Pharmacy: _____ Appointment Reminders OK? ☐ Yes ☐ No

Ok to leave message on: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Phone: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize WellSpring to provide my insurance companies with all information necessary to process insurance claims and assign payments to WellSpring all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: _____ Date: _____

A part of allcare Medical Group

Jon E. L. Ermshar, MD | Brett Rasmussen, PA-C

1716 Williams Hwy., Grants Pass, OR 97527 | **Phone** (541) 474-6053 | **Fax** (541) 474-4527

WELLSPRING
FAMILY PRACTICE

Authorization for Communication of Protected Health Information to Family and Friends

Patient Name _____ Date of Birth _____

Home Phone Number _____ Cell Phone Number _____

Address _____ City _____ State _____ Zip _____

I, _____, authorize WellSpring to discuss/share my protected health information with the following individual(s):

Name	Relationship	Phone Number

Type of information to be shared or disclosed:

- ☐ Appointment Information
- ☐ Medical Information
- ☐ Prescription Information
- ☐ Mental Health Information
- ☐ Lab/Imaging Results
- ☐ Any Information

☐ **I do not authorize** WellSpring to share my protected health information with any individuals.

I authorize WellSpring to leave detailed messages about my medical and health information on the following:

- ☐ Cell Phone Voicemail
- ☐ Home Phone Voicemail

Signature: _____ Date: _____

(This authorization shall remain in effect until revoked by the patient or for 1 year. You may request a new form at any time. Submitting a new form will replace the existing form.)

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WELLSPRING
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Medical Record Release

I hereby authorize:

Name of disclosing party

Address

City | State | Zip

To disclose to:

Name of recipient

Address

City | State | Zip

RECORDS AND INFORMATION FOR THE PAST TWO (2) YEARS PERTAINING TO:

Patient name (list other names used) | SSN | Date of Birth

Address | Phone number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

- ☐ Medical information _____ (initials)
- ☐ Psychiatric information — Signature | Date
- ☐ Drug/Alcohol Information — Signature | Date
- ☐ Results of HIV Test — Signature | Date
- ☐ Genetic Records — Signature | Date
- ☐ Other Health Information _____ (initials and specify below)
- ☐ Specify the records to be disclosed: _____

This authorization ☐ **does** / ☐ **does not** discontinue my care through WellSpring.

The recipient may use the health information authorized on this form for the following purposes:

_____

Signature | Date | If signed by other than patient, indicate relationship

(A copy of this authorization is as valid as the original. Patient has a right of receive a copy of this authorization.)

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WELLSPRING FAMILY PRACTICE

Health History

Name _____ Date _____

Date of birth _____ Referred by _____

Are you under the care of any other physician/provider? ☐ Yes ☐ No

Please list other health care providers _____

SOCIAL HISTORY

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

Men Only

Date of last prostate exam _____ Date of last PSA test _____

Date of last colonoscopy _____ Date of last Dexa Scan _____

LIFESTYLE

Exercise

What do you do? _____ How long? _____ How often? _____

Can you walk a block or climb a flight of stairs without getting short of breath? ☐ Yes ☐ No

Tobacco Use

Do you currently use any forms of tobacco? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? ☐ Yes ☐ No

If no, do you have a history of tobacco use? ☐ Yes ☐ No

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Have you had more than 4 drinks a day in the past 3 months? ☐ Yes ☐ No

Are you or others concerned about your drinking? ☐ Yes ☐ No

Falls

Have you fallen in the past year? ☐ Yes ☐ No

Do you have problems with walking or balance? ☐ Yes ☐ No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? ☐ Yes ☐ No

Do you regularly wear a seatbelt? ☐ Yes ☐ No

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WELLSPRING FAMILY PRACTICE

Health History *(continued)*

HIV Testing

Would you like HIV testing? ☐ Yes ☐ No (If yes, please tell the nurse). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Caffeine

How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Birth Control

Method (if applicable): _____

Sleep

Do you stop breathing during sleep or have concerns about sleep apnea? ☐ Yes ☐ No

Depression Screen

Recently, have you been bothered by little interest or pleasure in doing things, or feeling down, hopeless, or depressed? ☐ Yes ☐ No

Medications

Medications *(please list all)*	Dose *(Mg., pill, etc.)*	Times Per Week

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Do you have any trouble taking any of your medications? ☐ Yes ☐ No

Allergies

Allergies *(environmental, food, drug)*	Reaction *(symptoms)*	Severity

(If you need more room to list additional allergies, please write them on a blank sheet of paper with the required information)

Bladder Control

Do you lose control of your urine to the point you would like to know how to treat it? ☐ Yes ☐ No

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Health History *(continued)*

PAST MEDICAL HISTORY (check all that apply)

- ☐ Cancer (type and location) _____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart malformations
- ☐ Heart muscle disorders
- ☐ High blood pressure
- ☐ Hypothyroidism
- ☐ Other _____
- ☐ Coronary artery disease
- ☐ Heart infections/inflammation
- ☐ Heart rhythm
- ☐ Psychiatric condition

Diabetic Patients

Date of last foot exam _____ Date of last eye exam _____

Date of last A1c _____ Date of last cholesterol panel _____

PREVIOUS SURGERIES

	Type	Year	Surgeon	City
1				
2				
3				
4				

FAMILY HISTORY

Father (if living) Age _____ Health _____

Mother (if living) Age _____ Health _____

Father (if living) Age of Death _____ Cause _____

Mother (if living) Age of Death _____ Cause _____

Children

of Children _____ # living _____ # deceased _____ Ages of each _____

Serious illnesses of children

FAMILY MEDICAL HISTORY (Please check and note relationship. If grandparent, please specify paternal.)

- ☐ Cancer (type and location) _____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart malformations
- ☐ Heart muscle disorders
- ☐ High blood pressure
- ☐ Hypothyroidism
- ☐ Other _____
- ☐ Coronary artery disease
- ☐ Heart infections/inflammation
- ☐ Heart rhythm
- ☐ Psychiatric condition

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WELLSPRING FAMILY PRACTICE

Review of Symptoms

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

Constitutional Symptoms
- ☐ Fever
- ☐ Weight loss
- ☐ Extreme fatigue

Eyes
- ☐ Double vision
- ☐ Sudden loss of vision

Ears, Nose, Mouth, and Throat
- ☐ Sore throat
- ☐ Runny nose
- ☐ Ear pain

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools

Genitourinary
- ☐ Irregular menses
- ☐ Bloody urine
- ☐ Vaginal bleeding after menopause
- ☐ Frequent or painful urination
- ☐ Impotence

Skin
- ☐ Rash
- ☐ Changing Mole

Sleep
- ☐ Snoring
- ☐ Difficulty sleeping

Neurological
- ☐ Headache
- ☐ Persistent weakness on one side of the body
- ☐ Falling

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle weakness

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

Endocrine
- ☐ Excessive thirst
- ☐ Cold or heat intolerance
- ☐ Breast mass

Hematologic
- ☐ Unusual bruising or bleeding
- ☐ Enlarged lymph nodes

Allergic
- ☐ Hay fever

IF YOU HAVE ONE OF THE FOLLOWING CONDITIONS PLEASE ANSWER:

Diabetes
Any problems with medications? ☐ Yes ☐ No Home glucose readings: _____

High Blood Pressure
Any problems with medications? ☐ Yes ☐ No Home blood pressure readings: _____

High Cholesterol
Any problems with medications? ☐ Yes ☐ No

Depression
Any problems with medications? ☐ Yes ☐ No Any suicidal thoughts? _____

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Review of Symptoms *(continued)*

Please identify any issues on this form which are new or that you specifically want to address:

If you need help between appointments, please call our office at (541) 474-6053.

Our goal is to see you the day you call in or the next day. It is helpful if you call first thing in the morning. One of our nurses will help you decide if you need to be seen and if any tests are needed prior to your appointment.

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