BLUE MOUNTAIN CLINIC

610 N. California St. Missoula, MT 59802

PATIENT REGISTRATION

ALL INFORMATION IS CONFIDENTIAL

Legal Name(*please include middle initial and maiden name*)

Name you would like us to use: Your Pronouns

Sex on Legal Documents (please circle one)* Female Male Gender

*While we recognize a number of genders and sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and legal correspondence. If your name and pronouns are different from these, please let us know so we may address you appropriately and respectfully.

Birthdate / / Social Security # - -

Mailing Address:

Email Address:

Primary Phone ok to leave a message? ☐ Yes ☐ No

Secondary Phone ok to leave a message? ☐ Yes ☐ No

Can we identify ourselves as Blue Mountain Clinic when calling? ☐ Yes ☐ No

Occupation:

Employer Phone

Emergency Contact: Relationship to patient: Phone

Blue Mountain Clinic may verbally exchange health information with person(s) or organization(s) named below:

We will send certain correspondence, such as bills, to your mailing address. How would you prefer to receive other types of written correspondence? Patient Portal ☐ Letter ☐

Required by government mandate (although you may refuse):

Language: Race: Ethnicity: ☐Hispanic ☐Non-Hispanic

Marital Status: ☐single ☐partner ☐married ☐separated ☐divorced ☐widowed

What is the highest degree or level of school you have completed?

☐8th grade or less ☐9th-12th grade no diploma ☐High School graduate or GED ☐Some college by no degree

☐Associates Degree (AA, AS) ☐Bachelor's Degree (BA, AB, BS) ☐Master's Degree (MA, MS, Meng, Med, MSW, MBA, MPH)

☐Professional Degree (MD, DO, DDS, JD, DVM) ☐Doctorate (PhD, EdD)

Primary Insurance:

Plan Name:

Policy Number: Group Number:

Policy Holder Name: Policy Holder DOB:

Patient's relationship to policy holder:

Secondary Insurance:

Plan Name:

Policy Number: Group Number:

Policy Holder Name: Policy Holder DOB:

Patient's relationship to policy holder:

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MEDICAL HISTORY

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Patient #_____

Date_____

Legal Name(*please include middle initial and maiden name*)_____

Name you would like us to use:_____ Your Pronouns:_____

Sex on Legal Documents (please circle one)* Female Male Gender_____

Birthdate ____/____/____ Social Security # ____-____-____

Have you ever been a patient at Blue Mountain Clinic before?___Yes (date_____) ___No

What are your expectations from a primary care provider?_____

What are your current health goals?_____

FAMILY MEDICAL HISTORY: (Include parents and siblings)

Heart Disease _____ Stroke_____

Diabetes_____ Aortic Aneurysm_____

High Blood Pressure_____ Other_____

Cancer: ☐Colon_____ ☐Breast_____ ☐Other Cancer _____

PERSONAL MEDICAL HISTORY: (Include past and present)

Allergies to Medication_____

Other allergies_____

Current Medications & Doses (prescription and other)_____

_____

Age____Height____Weight____Blood type____Date of last Physical Exam_____

	Yes	**Comments/Dates**
Habits: Alcohol	____	_____
Tobacco	____	_____
Respiratory: Lung/Sinus problems, Asthma	____	_____
Cardiac: High Blood Pressure, Heart Murmur, High Cholesterol, Blood Clotting disorder	____	_____
Gastrointestinal Problems: Liver, Stomach, Gallbladder, Bowel, Heartburn	____	_____
Joint Problems: Pain, Swelling, Injury Arthritis	____	_____
Genital/Urinary Problems: Bladder, STD's Kidney, Sexual Function, Other	____	_____
Hormonal: PMS, Diabetes, Thyroid, Other	____	_____
Neurologic: Migraines, Seizures, Other	____	_____
Psychologic: Depression, Anxiety, Other	____	_____
Illness, Injuries, Surgeries, Hospitalizations:	____	_____

REPRODUCTIVE HISTORY:

Are you currently sexually active? ___Yes ___No
Do you consider yourself at risk for any sexually transmitted infections?_____
Have you undergone any sexual reassignment surgery? ___ Yes ___ No
If yes please list _____

IF APPLICABLE: ☐ N/A

Do you have a current method of Birth Control?_____
How long have you used?_____ Problems?_____
Are you postmenopausal? ___ Yes ____ No
Have you had a hysterectomy? ___ Yes ____ No
What was the first day of your last menstrual period?_____Date of last Pap Smear_____
Have you ever had any of the following:

1. Abnormal Pap Smear ___Yes ___No Dates & Treatment_____
_____

2. History of uterine abnormality, fibroid, infection or surgery ___Yes ___No
Comments, including dates and treatment_____
_____

3. Spotting or bleeding since your last period ___Yes ___No

Do you have regular periods? ___Yes ___No Problems_____

Do you think you might be pregnant now? ___Yes ___No
Have you had intercourse without birth control since your last period? ___Yes ___No

Previous pregnancies? ___Yes ___No
Live births #____ Abortions#____ Miscarriages#____ Still births# ____
Ectopic# ____ Cesarean# ___ Multiple births____
Deceased children/cause_____

Date last pregnancy ended (regardless of how ended)_____
Dates and complications, if any, of pregnancies_____

PREVENTION (50 YEARS OR OLDER)

Bone dexa scan: Year_____ Result_____
Colon Cancer test:
o Colonoscopy Year_____ Result_____
o Stool Year_____ Result_____
Abdominal Aortic Year_____ Result_____
Hepatitis C Screen Year_____ Result_____
Shingles Vaccine Year_____Pneumonia Vaccine Year_____
Have you had falls in the last month? (over 50 yo) __ Yes __ No How many? ____
Do you have a health care power of attorney or code status designated? __ Yes __ No
Would you like advice on this today? __ Yes __ No
Do you have urinary incontinence? __ yes __ No

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610 N California St ·Missoula, MT 59802
(406)721-1646 · 800-727-2546 · FAX (406)543-9890
www.bluemountainclinic.org

Authorization for Release of Information

Patient Name_____
Last First Middle Other Name

Date of Birth_____/_____/_____SS#_____/_____/_____Phone_____
Address_____City_____State_____Zip_____

OR

☐ I authorize Blue Mountain Clinic **to release information to** the following provider:	☐ I authorize Blue Mountain Clinic **to obtain information from** / I authorize this provider to release information to Blue Mountain Clinic:
Name of provide r or facility	*Name of provider or facility*
Address	*Address*
City, State, Zip code	*City, State, Zip code*
Phone number, fax number (include area code)	*Phone number, fax number (include area code)*

OR ☐ **I am requesting a copy of my records for my own use.**
Please_____Fax _____Mail_____Contact me to pick up records from the clinic

Information to be released:

___Progress (Visit) Notes
___Lab Reports
___X-Ray Reports
___All Records
__Other (please describe): _____
_Records relating to a specific illness or injury:
_____dates: _____
(specify illness or injury)

Please specify the reason for disclosure:

___Changing Physicians ___Consultation/Second Opinion ___Continuing Care
___Legal ___School ___Insurance
___Other (please specify)_____

1. I understand that this authorization will expire 180 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by my provider, my health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I have signed it.

Signature of Patient (or representative)_____Date_____

If representative, relationship to patient (i.e. parent, guardian,etc.) _____