BLUE MOUNTAIN FAMILY MEDICINE
610 N. California St. Missoula, MT 59802
MEDICAL HISTORY
ALL INFORMATION IS CONFIDENTIAL

Date________________________

Blue Mountain Clinic may verbally exchange health information with person or organization named below

____

**All information on this medical history is strictly confidential. We will not release this information to anyone without your specific, signed consent.

Have you ever been a patient at Blue Mountain Clinic before?____Yes (date__________) ____No
Reason For Today's Visit____
Legal Name(*please include middle initial and maiden name*)________________________
Preferred Name____________________What pronoun do you use?________Birthdate____/____/____SS #______/_____/______
Address________________________________City____________________State____ZIP____________________
Primary Phone____________________E-mail______________________________________
Employer__________________________________Work Phone____________________________
Parent or guardian's name______________________________Phone Number____________________
Emergency Contact: Name__________________________Phone_______________Relationship________________
Special Instructions for contacting you, including the use of your preferred name:

____

Are you establishing Primary Care or care for Contraception/Abortion/IUD/Nexplanon/STI testing only?
Primary care ☐ Contraception/Abortion/IUD/Nexplanon/STI testing ☐ Both ☐

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)

Age_____Height_____Weight_____Blood type_____Date of last Physical Exam____________________
Allergies to Medication____

____

Shellfish allergy ____yes ____no Latex allergy ____ yes ____no

Pharmacy of Choice:____

Current Medications & Doses (attach list if needed)

Name	Strength in mg/ml	Number of times a day taken

Specialist clinics or physicians you currently see:______________________________

____

Surgeries, Hospitalizations: (list year if can)

____

____

Do You Use Tobacco products? Yes No If yes, how much____________________

If you quit, when________________

Do You Drink Alcohol? Yes No If yes, how much____________________

If you quit, when________________

For Everyone Please answer and comment if needed. **Do you have any of the following?**

☐ EYE/EAR DISEASE	☐ ASTHMA	☐ COPD	☐ BLOOD CLOT/ DVT/PE	☐ ANEMIA/ BLOOD DISEASE	☐ HIGH CHOLESTEROL
☐ATRIAL FIBRILLATION	☐ HEART ATTACK/ HEART DISEASE	☐ MURMUR/ HEART VALVE DISEASE	☐ HYPERTENSION	☐ DIABETES	☐ CHRONIC CONSTIPATION
☐ DIARRHEA	☐ IBS	☐ ANXIETY	☐ DEPRESSION	☐ BIPOLAR	☐ OTHER MENTAL HEALTH
☐ ADD/ADHD	☐ BRAIN INJURY	☐ KIDNEY DISEASE	☐ RECURRENT UTI/ BLADDER DISEASE	☐ KIDNEY STONES	☐ GERD/REFLUX/ ULCER
☐ ENDOMETRIOSIS	☐ OVARIAN CYSTS	☐ UTERINE FIBROIDS	☐ THYROID DIISEASE	☐ HERPES	☐ HEPATITIS/HIV
☐ ARTHRITIS	☐ FIBROMYALGIA	☐ MIGRAINES/ HEADACHES	☐ GOUT	☐ OSTEOPOROSIS	☐ MS
☐ BREAST CANCER	☐ COLON CANCER/ POLYPS	☐ PROSTATE CANCER	☐ OTHER CANCER	☐ OBESITY	☐ ADDICTION ISSUES

Comments on Above____

____

Sexual HISTORY:

Are you currently sexually active? ___Yes ___No

Are you concerned about any current possibilities of sexually transmitted infections? ___Yes ___NO

Have you undergone any gender confirming surgery? ___ Yes ___ No

If yes please list ____

Gynecological history IF APPLICABLE: ☐ N/A

Do you have a current method of Birth Control? _____Yes ___No type:____________________

How long have you used?____________________ Problems?____________________

Do you see yourself desiring a pregnancy in the next year? _____Yes _____No

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. Migraines with aura ___Yes ___No
3. Blood clot disorder or blood clot in your leg or lungs? ____Yes ___No

Do you have regular periods? ___Yes ___No ____ Post Menopause 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 Date last pregnancy ended? ______________

Live births #____ Abortions#____ Miscarriages#____ Still births# _____

Ectopic# ____ Cesarean# ____ Multiple births____Deceased children ___

Prevention (50 Years or older)

	Year	Result		Year	Result
Bone dexa scan			Hepatitis C screen		
Colon Cancer test Colonoscopy ☐ Stool ☐			Shingles vaccine		
Abdominal Aortic			Pneumonia		

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

Please provide us with your insurance information.

Primary Insurance ______________________________

Insurance ID Number______________________________

Policy Holder's Name______________________________

Secondary Insurance______________________________

Insurance ID Number______________________________

Policy Holder's Name______________________________

CREDIT AND BILLING POLICY

Thank you for choosing Blue Mountain Clinic for your health care needs! Please take a moment to read over our credit and billing policies.

INSURANCE PAY - We require all co-payments to be made at the time of service, and payment in full for any deductibles and services not covered by your policy. It is *your* responsibility to ensure that the Clinic has your correct insurance information and to make sure that the services provided are a benefit of your contract. If your insurance has a Preferred Provider Network, you will be responsible for verifying participation of any physician involved in your care. If you have a secondary insurance we will submit the claims for you. *For your convenience we accept cash, checks, credit cards, and We Trade.*

It is important that you understand that your contract with an insurance company is between you and them; therefore, the ultimate responsibility for payment belongs to you. Each plan is different, and filing with insurance is no guarantee that services will be paid for.

PRIVATE PAY - Payment in full is due at the time of service.

******* - If your medical care is due to an injury and/or an accident (i. e. Workers Compensation or Motor Vehicle Accident), please have ready the claim number, name of claim adjuster, phone number, correct billing address and date of injury.*****

We reserve the right to charge interest on any account over 60 days.

LAB POLICY - Blue Mountain Clinic is able to offer many lab tests in house. There is no assurance that lab work will be covered by your insurance. Certain tests (such as pap tests, pathology, and some blood work) must be sent to labs outside of Blue Mountain Clinic. We will forward your insurance information, although we cannot guarantee what will be covered, nor what the exact charge will be. Please be aware you will receive a *separate bill* from these other facilities. *You must contact the outside lab directly if you have any billing questions.*

COLLECTION POLICY - Our collection policy consists of an initial statement being billed following payment by insurance. If no payment is received, a second statement will be sent, and considered past due. Should no payment be made during that time, a third statement will be sent with a final notice letter. You will have 10 days to make payment arrangements. If no payment or contact is made you will be turned over to collections. ALL THIRD PARTY COLLECTION FEES WILL BE YOUR RESPONSIBILITY. These fees may include agency fees, attorney fees, and a collection fee of up to 50% of the account total added to the balance.

DISCHARGE POLICY- It is our policy to discharge patients from our practice who have been turned over to collections.

Because Blue Mountain Clinic's healthcare philosophy centers around our clients, it is of the utmost importance that you come to your appointments. It is our policy that you cancel at least 24 hours prior to your appointment. If you do not, you may be subject to a* *$25.00 fee****, and may not be able to continue your care at BMC.*

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

______________________	______________________	______________________
Signature of Responsible Party	*Print Name*	*Date*