ASHBROOK MEDICAL
FAMILY PRACTICE
5512 NE 107th Ave.,
Vancouver, WA 98662

(360) 892-2030 Fax: (360) 892-1999

Dear Patient:

Welcome to our office. Our practice specializes in family practice medicine. My staff and I are here to help you obtain the care you need in a pleasant and efficient manner. We are happy to answer any questions you might have and to explain our billing procedures, outlined below.

We will bill your primary insurance company directly, providing that we have all your pertinent billing information, a copy of your medical card, and a current address for your insurance. Please remember that it is your responsibility to inform and supply a copy of any changes with your primary insurance company or when you receive new copies of your card - there are changes that the insurance companies do make at times, and it's important for you to make sure we have those changes. If you have a secondary coverage it will be your responsibility to submit charges after your primary carrier has paid. You will receive a monthly statement regarding any balance due once this claim has been processed by your primary insurance.

There are some insurance types we do not participate with, so please check with the front desk before you are seen to make sure the visit will be covered. If you belong to an HMO or PPO, please make your co-payment at the time of your office visit.

As you know, managed care has presented many challenges to running a medical practice. Most insurance companies require a referral from your primary care physician in order to see a specialist. We process our referrals as quickly as we can and ask that unless it is an emergency, please be patient with us. We take pride in taking care of our patients, all of them, and that does not always leave much time to process a referral as quickly as we would like; but we can assure you we will always work hard to take good care of you.

Please feel free to discuss any aspect of your treatment, account or office policy with me, my office manager or my staff.

FOR INSURANCE PURPOSES: I authorize the release of medical information to my insurance company and assign all insurance benefits to Ashbrook Medical Family Practice, P.S. Please understand that if your insurance does not cover any or only part of your office visit that you are responsible.

Signed: _____
(Patient / Guardian/ Responsible Party if under 18 year of age)

Sincerely,

Rick L. Jackson, M.D.

Ashbrook Medical Family Practice

PERSONAL INFORMATION SHEET:

Please fill in the following to the best of your knowledge, if you have any questions please ask your doctor or nurse upon entering the exam room. Thank You.

Name: _____ Date of Birth: _____

Sex: Male or Female Height: _____ Weight: _____

Marital Status: Married / Divorced / Single / Widowed Other: _____

# of Children: _____ Work Status: In Home / Outside of Home

PERSONAL MEDICAL HISTORY:

Major Medical Illnesses or disease: 1) _____ 2) _____
3) _____ 4) _____

Surgeries: 1) _____ 2) _____ 3) _____
4) _____ 5) _____

HABITS: (Please be sure to list any occasional use or recreational drug use.)

Cigarettes _____ Alcohol _____ Caffeine _____ Other _____

ALLERGIES: Please be sure to list any drug reactions or iodine, shellfish allergies, etc.

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Date of Last Tetanus Shot: _____

OB / GYN: All females please fill in this section to the best of your ability.

Type of birth control: _____
Number of Pregnancies: _____
Number of Miscarriages: _____
Number of Abortions: _____
Number of Premature births: _____

Menstruation: (circle -current description of your cycles)

Regular
Irregular
Postmenopausal

Authorization to Discuss Protected Health Information

Print patient's legal name _____

Previous names_____ Birthdate____/____/____

1. Phone Messages

The staff/doctors at Ashbrook Medical Family Practice may leave information on my voicemail or answering machine at these numbers:

Home:_____Cell:_____Work:_____

2. Person-to-Person Communication

To help with my care or billing, Ashbrook Medical Family Practice may share information with these people:

First name, last name	relationship	Contact Number
First name, last name	relationship	Contact Number
First name, last name	relationship	Contact Number

I Understand the following:

- This consent applies to Ashbrook Medical Family Practice staff and doctors.
- Ashbrook Medical Family Practice will release all details to the person(s) named above. This includes all details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. If I **DON'T** want this information shared, I will write my initials here:_____
- This form does not have an end date. If I want to change the information on this form, I will fill out a new form. If I want to add or remove people for person-to-person communication, I will fill out another form.
- Once my information is shared with the person(s) named above, it may no longer be protected by privacy laws. Ashbrook Medical Family Practice cannot prevent these persons from sharing my information with a third party.
- If I do not sign this form, I will still be treated.

X_____ _____

Signature of Patient Date

X_____ _____

Signature of authorized person or parent of minor Date

NAME: _____ DATE: _____

FAMILY HISTORY: Please fill in any history of Major illness or disease in any of your sides of family, and please list what family member it was that had the illness/disease. Please indicated if the person is living or deceased. Thank you.

FATHER: - Alive (age) _____ Deceased (age) _____ Cause of Death? _____
Medical Problems? _____

MOTHER: - Alive (age) _____ Deceased (age) _____ Cause of Death? _____
Medical Problems? _____

# of Siblings: _____ Living: _____ Died of : _____
Grandparents --- Medical Problems? _____
Aunts or Uncles – Medical Problems? _____

REVIEW of SYSTEMS :

		Past Problem -- or-- Ongoing (If "YES"– Explain)
Eyes ----------	YES / NO	_____
Ears ----------	YES / NO	_____
Nose ----------	YES / NO	_____
Throat ----------	YES / NO	_____
Head / Headaches -------	YES / NO	_____
Lungs ----------	YES / NO	_____
Heart/Vessels ------	YES / NO	_____
Bleeding Problems --	YES / NO	_____
Blood Pressure ----	YES / NO	_____
Liver ----------	YES / NO	_____
Gallbladder ---------	YES / NO	_____
Stomach ----------	YES / NO	_____
Bowels ----------	YES / NO	_____
Bladder / Urine ----------	YES / NO	_____
Kidneys ----------	YES / NO	_____
Prostate -- ----------	YES / NO	_____
Reproductive Organs -	YES / NO	_____
Diabetes ----------	YES / NO	_____
Thyroid ----------	YES / NO	_____
Glandular Problems ---	YES / NO	_____
Seizures ----------	YES / NO	_____
Other Neurological Disorder	YES / NO	_____
Paralysis / Dizziness --	YES / NO	_____
Mental / Emotional -----	YES / NO	_____
Serious Infections -----	YES / NO	_____
Cancer or Tumors -----	YES / NO	_____
Arthritis, joint or muscle Disorder	YES / NO	_____
Other disease/condition	YES / NO	_____

Any Blood Transfusions - YES / NO If "Yes" – Explain: _____
IV Drug Use: YES / NO If "Yes" – Explain: _____