The Everett Clinic
Part of Optum®

Island Internal Medicine | La Conner Medical Center
PLEASE DO NOT LEAVE FIELDS BLANK

Date

Legal First Name | Middle Initial | Last Name | Birthdate

Street and Apt # | City | State | Zip Code

Primary Telephone | Alternate Telephone | *Previous/Referring* Provider

Social Security Number | Employer | Employer Phone # | Provider you wish to establish with

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Dependent
- ☐ Widow

Race
- ☐ White/Caucasian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Prefer Not to Disclose
- ☐ Other_____

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer Not to Disclose

Gender
- ☐ Male
- ☐ Female
- ☐ Transgender

Would you like access to our **patient portal** and to receive lab notifications on-line?
- ☐ Yes
- ☐ No

If yes, please provide your email address

Pharmacy Name | City and State

Emergency Contact Full Name | Relationship | Phone #

Parent/Spouse/Partner Full Name | Relationship | Phone # | Employer

BILLING INFORMATION

PRIMARY INSURANCE	
Insurance Company	
Subscriber Name	
Birthdate	
Group #	
ID #	
Subscriber's Employer	

SECONDARY INSURANCE	
Insurance Company	
Subscriber Name	
Birthdate	
Group #	
ID #	
Subscriber's Employer	

BILLING CONTACT | Complete *only if* the person responsible for the bill is *not the patient*.

First Name | Middle Initial | Last Name | Relationship

Street and Apt # | City | State | Zip Code

Primary Telephone | Employer | Employer Phone #

Employer Address

IIM LCMC NEW PATIENTS | Incomplete Forms Will Be Returned

The Everett Clinic
Part of Optum®

Island Internal Medicine | La Conner Medical Center

HEALTH HISTORY

Legal First Name	Middle Initial	Last Name	Birthdate

MEDICATION LIST				
Start Date & End Date	**Name of Medication** (Prescriptions, Over-the-Counter, and Supplements)	**Strength** (e.g. the number of mg per pill)	**Dosage** (How many pills or mg do you take at a time?)	**Frequency** (How often do you take that dose? E.g. once a day, twice a day, as needed, etc.)

I acknowledge that I have listed ALL medications, including medications for chronic pain.

_____*(initial)*

ALLERGIES & SENSITIVITIES – please list below the medication & side effect

Please mark which vaccines you've received and the date it was given:

Tetanus Diphtheria (TD):	Yes	Date:	No
Tetanus Diphtheria & Pertussis (TDAP):	Yes	Date:	No
Pneumococcal 23 (PPSV23):	Yes	Date:	No
Prevnar 13 (PCV13):	Yes	Date:	No
Zostavax:	Yes	Date:	No
Shingrix:	Yes	Date:	No

ADVANCED DIRECTIVE or LIVING WILL?

Yes	Yes
No	No

List medical problems that other doctors have diagnosed	
1.	
2.	
3.	
4.	
5.	
6.	

List surgeries, hospitalizations, major injuries & dates if known	
1.	
2.	
3.	
4.	
5.	
6.	

The Everett Clinic
Part of Optum®

Island Internal Medicine | La Conner Medical Center

HEALTH HISTORY CONTINUED....

Legal First Name	Middle Initial	Last Name	Birthdate

Children	
Age	**Gender**

Family Health History			
Family Member	**Age *if Alive***	**Age *at Death***	**Significant Health Problems**
Father			
Mother			
Sibling (M / F)			
Sibling (M / F)			
Sibling (M / F)			

Women Only	
Onset of Menstruation	
Last Menstrual Period	
Last Colonoscopy	
Date of Last Pap Smear	
Date of Last Mammogram	
History of Abnormalities:	
# Pregnancies	
# Live Births	
# C-Sections	
Did you have a hysterectomy?	

Men Only	
Last Prostate Exam	
Last Rectal Exam	
Last Colonoscopy	
History of Abnormalities:	

Diseases	List Relatives Affected
Cancer / What Kind?	
Diabetes	
Stroke	
Heart Disease	
Heart Attack	
High Blood Pressure	
High Cholesterol	
Osteoporosis	
Depression	

ALCOHOL
Yes # drinks/week:_____
No None

TOBACCO
Yes Quit date:_____
No Never

CIGARS/PIPES/CHEW
Yes #/day:_____
No # years:_____

CAFFEINE
Yes # cups/day:_____
No None

CIGARETTES
Yes Packs/day:_____
No None

EXERCISE
Yes Days/week:___
No Never

Medical Record Number: _____

Request for Alternative Means of Confidential Communications

Patients Name: _____ DOB:____/__/_____

Patients Primary MD: _____Clinic Name/Location: _____

Patient Primary Address: _____City:_____State:____Zip: ____

I request that Optum Care communicate with me by alternative means or at alternative locations for reasons of confidentiality. I understand that Optum Care will comply with reasonable requests and will inform me directly and in writing if they are unable to comply with my request. Optum Care will not ask for any reason for this request. **(Please note that texting between patients and Optum Care is not an acceptable secure communication format)**

Do you wish to indicate an alternate mailing address: □ Yes □ No If yes please provide the alternative address;

Street: _____ Apt/Unit Number: _____

City: _____ State: _____ Zip Code: _____

Do you wish / authorize Optum Care to contact you via phone: □ Yes □ No

If yes, indicate which number. ☐Home Phone ☐Work Phone ☐ Cell Phone: ( ) _____-_____

Additional Method of Contact: _____

Do you authorize Optum Care to release your information including diagnosis, treatment, medical records and claims information to the individuals listed? □ Yes □ No

If yes please identify:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

I agree that this change will not affect my payment responsibility or processes necessary to obtain payment for Optum Care services. I understand that, if approved, this request will remain in effect until I terminate or change this request, at any time, by notifying Optum Care in writing.

Signature: _____ Date: ___/___/_____

If personal representative, print name: _____ Relationship: _____

Internal Use Only: Name of teammate receiving form: _____ Date: ___/___/_____
Request Approved □ Yes □ No If approved ensure documented in appropriate systems and staff notified
If request denied provide reason for denial: _____
If denied patient must be notified in writing with denial reason

The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

PATIENT LABEL HERE

OR

Patient Name _____

Date of Birth _____

MRN _____

ACKNOWLEDGMENT OF RECEIPT OF THE EVERETT CLINIC'S NOTICE OF HEALTH INFORMATION PRACTICES

I understand that as part of my healthcare, The Everett Clinic creates and maintains health records describing my health history, symptoms, examination with test results, diagnosis(es), treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my case
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a copy of The Everett Clinic's "Notice of Health Information Practices" summary, which provides a description of information uses and disclosures. I understand, I have the right to request a complete copy of the "Notice of Health Information Practices".

I understand that The Everett Clinic reserves the right to change their notice and practices; including prior to implementation. Changes will be posted at all clinic sites and on our website and notice of changes will be published in the quarterly newsletter.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or normal healthcare operations and that The Everett Clinic is not required to agree to the restrictions, I have requested.

- ☐ **I have received a copy of The Everett Clinic's Summary of Health Information Practices Notice.**

Please **print** patient name _____

_____ _____

Signature of Patient or Legal Representative | Name of Minor Child

_____ ☐ **Reception:** If patient refuses, please put your initials in box.

Date Signed (or Date Refused)

The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966
www.everettclinic.com

PATIENT LABEL HERE

OR

Patient Name_____

Date of Birth_____

MRN_____

AUTHORIZATION AND CONSENT

TO ACCESS PRESCRIPTION HISTORY FROM RXHUB

Disclosure: RxHub is a National Patient Health Network, which provides secure access to prescription coverage information. It serves as a nationwide e-Prescribing information exchange network. This real-time information is used by my physician to prescribe the most clinically appropriate and cost effective medication.

The Everett Clinic will submit a request to RxHub for information regarding my pharmacy eligibility, benefit and formulary and medication(s). The request is based on my full name, date of birth, gender and zip code. RxHub will release my medications, including prescriptions for treatment of sensitive diagnoses (STDs, HIV/AIDS, Drug/Alcohol, and Mental Health).

My medication(s) list will be updated based on the information obtained from the RxHub including those that were obtained from provider(s) outside of The Everett Clinic and may include those prescribed for the treatment of sensitive diagnoses (STDs, HIV/AIDS, Drug/Alcohol, and Mental Health).

My physician will prescribe the necessary medication(s) and generate the prescription(s) to the pharmacy of my choice. The prescription(s) will be electronically routed to the pharmacy of choice.

Consent:
I hereby authorize and consent to allow The Everett Clinic to access my pharmacy prescription information, as needed, through the RxHub information exchange system as described above. I understand that my medication information will be updated and may include those medications prescribed for the treatment of sensitive diagnoses (STDs, HIV/AIDS, Drug/Alcohol, Mental Health).

The consent period is in effect from the date on this form until I revoke/rescind it, in writing, by me.

Signature: _____ **Date:** _____

Signed by: **[ ] Parent** **[ ] Guardian** **[ ] Other** _____

Revoke/Rescind:
If you choose to revoke/rescind your consent to allow The Everett Clinic to access my pharmacy prescription information from RxHub you must notify the Clinic in writing. We need your complete name, date of birth, telephone number (home/work). The notice to revoke/rescind must be sent to Health Information Management (Medical Records), The Everett Clinic, Everett, WA 98201.

The Everett Clinic
Part of Optum®
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

PATIENT LABEL HERE

Authorization to bill and treat

AUTHORIZATION:

I have received a copy of The Everett Clinic's billing procedure. I authorize The Everett Clinic to release to my insurance company any medical information which may be necessary for processing my claim. I assign benefits paid by my insurance company to be paid directly to The Everett Clinic.

I consent to treatment of my health condition(s) by providers of The Everett Clinic.

If I fail to provide accurate insurance billing information in a timely manner, I may be financially responsible for charges denied by my insurance.

Signature of Patient: _____

Date: _____

If not patient, relationship to patient Relationship to patient: _____