St. Joseph Regional Medical Center

New Patient Forms

DATE: _____

Please Select a Provider:
____Amy Johnson, NP ____Tyler Clark, MD ____Tamara Bruns, DNP ____Michael Baldeck, DO ____Donald Greggain, MD ____Barbra Davis, MD

Patient Information (as it appears on insurance card)

Patient Name _____ Date of Birth ___/___/____ Male ☐ Female ☐
Mailing Address _____ City _____ State _____ Zip _____
Phone # _____ Phone Type _____ Alt Phone # _____ Phone Type _____
Email _____ Social Security # _____
Other Last Name(s) Used _____ Preferred Language _____
Race ☐ African American ☐ Alaska Native ☐ American Indian ☐ Caucasian ☐ Hispanic or Latino ☐ Native American ☐ Other _____
Guarantor (Full Name) _____ Guarantor Date of Birth ___/___/____

Emergency Contact Information

Name _____ Phone # _____ Phone Type _____
Relationship to Patient _____

Insurance Information

Primary Insurance _____ Subscriber Name _____
Policy/ID # _____ Group # _____ Phone # _____ Phone Type _____
Secondary Insurance _____ Subscriber Name _____ Date of Birth ___/___/____
Policy/ID # _____ Group # _____ Phone # _____ Phone Type _____

Employer Information

Employer Name _____ Phone # _____ Phone Type _____
Address _____ City _____ State _____ Zip _____ ☐ Full-time ☐ Part-time

Reason for Visit/Establishing Care - Current/Past Medical Problems

Accident Related? ☐ Yes ☐ No Previous Primary Care Provider _____ Date Last Seen _____
How often do you go to the doctor in a year? _____ Do you have any family members that see one of our providers? ☐ Yes ☐ No
Who recommended you to our clinic or how did you hear about us? _____

Allergies - Please list any allergy or intolerance you have to medications or environment (i.e. dust, nuts, animals)

Medication or Environmental Issue	Reaction

Current Medications - Include all prescription and non-prescription (over-the-counter) medications

Medication Name	Dose (mg, mcg, %)	How Often?

If you are not currently taking any medications (prescription or over-the-counter), check here ☐

NEW PATIENT FORMS

Past Medical History

Have you had a colonoscopy? ☐ Yes ☑ No If yes, when? _____ Providers Name _____

Women: Age when menses began _____ If post-menopausal, when was your last period? _____

At what age did you have your first child? _____ Total number of pregnancies _____ Miscarriages? _____

Have you had any of the following? (list type if requested)	Yes	No	Date Issue Began
Acid Reflux	☐	☒	
Anemia	☐	☒	
Anxiety	☐	☒	
Arthritis	☐	☒	
Asthma	☐	☒	
Bleeding Tendency	☐	☒	
Blood Clots	☐	☒	
Blood Disorder - Type?	☐	☒	
Bowel Disease - Type?	☐	☒	
Cancer - Type?	☐	☒	
Chronic Muscle Pain	☐	☒	
Daytime Sleepiness	☐	☒	
Depression	☐	☒	
Diabetes - Type?	☐	☒	
Gallbladder Problems	☐	☒	
Gout	☐	☒	
Heart Trouble	☐	☒	
Hepatitis - Type?	☐	☒	
Hereditary Defect - Type?	☐	☒	
High Blood Pressure	☐	☒	
High Cholesterol	☐	☒	
Insomnia	☐	☒	
Joint Pain	☐	☒	
Kidney Failure	☐	☒	
Kidney Stones	☐	☒	
Liver Disease	☐	☒	
Lung Problems - Type?	☐	☒	
Migraines	☐	☒	
Osteoporosis	☐	☒	
Pancreatitis	☐	☒	
Rheumatic Fever	☐	☒	
Seizures	☐	☒	
Sexually Transmitted Disease - Type?	☐	☒	
Stomach Ulcers	☐	☒	
Stroke	☐	☒	
Substance Abuse Disorder - Type?	☐	☒	
Thyroid Gland Trouble	☐	☒	
Tuberculosis (TB) - Exposure or Contracted?	☐	☒	
Ulcers - Type?	☐	☒	
Other - Please Describe:			

Additional Medical Issues	Year Issue Began

Past Surgeries - List Type of Surgery	Year

Immunization History - Do not fill out unless you have specific dates	Month/Day/Year
Pneumovax (Pneumonia Vaccine)	
Zostavax (Shingles Vaccine)	
Tetanus	
PPD (Tuberculin Skin Test)	
Hepatitis A	
Hepatitis B	
Meningococcal	
MMR (Measles, Mumps, Rubella Vaccine)	
Varicella (Chickenpox Vaccine)	
Other - Please List:	

Family History - List which relative (i.e. mother, father, brother, sister, aunt, uncle, maternal/paternal grandparent, etc.)		
Illness	**Family Members (please list)**	**If grandparent, maternal or paternal?**
Arthritis		
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		
Heart Attack		
Migraines		
Seizures		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		

Social History

Marital Status (please choose) ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Do you smoke? ❑ Yes ❑ No Frequency? _____ Did you smoke in the past? ❑ Yes ❑ No

How many years did you smoke? _____ When did you quit smoking? _____

Do you use smokeless tobacco? ❑ Yes ❑ No Frequency? _____ Did you use smokeless tobacco in the past? ❑ Yes ❑ No

How many years did you use smokeless tobacco? _____ When did you quit using smokeless tobacco? _____

Do you drink alcohol? ❑ Yes ❑ No How much/frequency? _____

Do you smoke marijuana? ❑ Yes ❑ No How much/frequency? _____

Do you use recreational drugs? ❑ Yes ❑ No Type _____ How much/frequency? _____

My Health Portal

My Health Portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information such as, recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results, upcoming radiology appointments, and more.

Have you signed up for My Health Portal? ❑ Yes ❑ No If no, please check here if you would like to sign-up ❑

Pharmacy Preference

Pharmacy Name _____

Pharmacy Address _____ City _____ State _____ Zip _____

Pharmacy Phone # _____ Pharmacy Fax # _____

Additional Comments: _____

_____

_____

_____

_____

DROP OFF AT: 307 ST JOHNS WAY, STE 5 LEWISTON, ID 83501
FAX TO: 208-750-7219
FOR ANY QUESTIONS: 208-750-7355

ST. JOSEPH
Regional Medical Center