MERCY & WISDOM
COMMUNITY HEALTH CLINIC

7411 SE Powell Blvd. Portland, Oregon 97206
Tel: (503) 227-1222 Fax: (503) 227-1555
Online: www.mercyandwisdom.org
501(c)(3) Tax ID #76-0767257

PATIENT HEALTH HISTORY/DEMOGRAPHIC INFORMATION

All demographic data will be kept confidential and will be used solely for statistical purposes. This information is needed in order for us to access grants, donations, and other assistance programs that are vital to the continuation of our clinic. Your participation is not mandatory; however, it is greatly appreciated.

Patient's Name: _____ _____ _____
First -Legal Preferred Name Last

Address: _____ City: _____ State: _____

Zip: _____ Phone Number: (____)_____ Email:_____

Birth Date: _____ Sex: ❑ F ❑ M ❑ MTF ❑ FTM ❑ Non Binary

INSURANCE: ❑ Medicaid/ OHP ❑ Private Insurance ❑ No Insurance ❑ PPC

RACE (Circle One or More)

Black/African American Asian Caucasian/White Other

Hawaiian/Pacific Islander Hispanic/Latino Native American/Alaskan Native

Migrant Status: Yes No
Primary Language: _____ Interpreter Requested: Yes No

Employer: _____ Occupation: _____

MARITAL STATUS: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced

HOUSEHOLD INCOME: *The total income that supports you, your spouse or partner, and your dependents. A dependent is anyone 18 or under for whom you provide 50% or more of all financial support. Income* ***does*** *include SSI and unemployment benefits.*

Gross Monthly Income: ❑ Under $2,000/month ❑ Over $2,000/month
(If Applicable) Number of dependents: _____
Spouse/Partner's Monthly Income: _____

EMERGENCY CONTACT: _____ Relationship: _____
Name
Telephone Number: (____)_____
Email: _____

We require at least 24 hours advance notice for cancelling appointments.

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	
					Other:	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Other History

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

Have you ever been tested for HIV? ☐ Yes ☐ No

Please list the shots/vaccinations you've had:

Health Habits

(✓)		How much?
	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Are you interested in receiving smoking cessation services today?

□ Yes □ No

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other:

Occupation

_____

Symptoms Check (✓) symptoms you currently have or have ever had in the past.

GENERAL
☐ Fever
☐ Chills
☐ Headaches
☐ Head Injury
☐ Migraine Headaches
☐ Jaw/TMJ Problems
☐ Hair Loss
☐ Dizziness
☐ Hair Loss
☐ Forgetfulness
☐ Loss of sleep
☐ Loss of weight
☐ Sweats

EYE, EAR, NOSE, THROAT
☐ Persistent cough
☐ Sore Lips/Tongue
☐ Frequent Sore Throat
☐ Double vision
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Vision – Flashes
☐ Vision – Halos
☐ Eye Pain/Strain
☐ Spots in eyes
☐ Cataracts
☐ Glaucoma
☐ Color Blind
☐ Glasses/Contacts
☐ Tearing/Dryness
☐ Earache
☐ Ear discharge
☐ Ringing in ears
☐ Loss of hearing
☐ Hearing Impaired
☐ Nosebleeds
☐ Hay fever
☐ Stuffiness
☐ Loss of Smell
☐ Frequent Colds
☐ Hoarseness
☐Bleeding gums
☐ Jaw Clicks
☐ Gum Problems
☐ Cavities
☐ Sinus problems

NECK
☐ Lumps
☐ Goiter
☐ Swollen Glands
☐ FeverPain or Stiffness

SKIN
☐ Bruise easily
☐ Hives
☐ Acne/Boils
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal
☐ Eczema/Psoriasis
☐ Color Changes
☐ Lumps

CARDIOVASCULAR
☐ Varicose veins
☐ Chest pain
☐ High blood pressure
☐ Irregular heartbeat
☐ Low blood pressure
☐ Poor circulation
☐ Swelling of ankles
☐ Angina
☐ Murmur
☐ Heart Disease
☐ Blood Clots
☐ Rheumatic Fever

MUSCLE/JOINT/BONE
☐ Anemia
☐ Cold hands/feet
Pain, weakness, numbness in:
☐ Arms ☐ Hips ☐ Back
☐ Legs ☐ Neck ☐ Feet
☐ Hands ☐ Shoulders
☐ Arthritis
☐Muscle Spasms
☐ Broken Bones
☐ Sciatica

RESPIRATORY
☐ Asthma
☐ Cough
☐ Sputum
☐ Pleurisy
☐ Wheezing
☐ Bronchitis
☐ Pneumonia
☐ Emphysema
☐ Tuberculosis
☐ Spitting up blood
☐ Difficulty breathing
☐ Pain with breathing
☐ At nigh
☐ Lying down

GASTROINTESTINAL
☐ Gall bladder disease
☐ Appetite poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood
☐ Ulcers
☐ Jaundice
☐ Heartburn
☐ Liver Disease
☐ Black Stool
☐ Abdominal Pain

EMOTIONAL
☐ Mood Swingst
☐ Nervousness
☐ Tension/Stress
☐ Anxiety
☐ Depression

ENDOCRINE
☐ Cold Intolerance
☐ Hypothyroid
☐ Hyperthyroid
☐ Heat Intolerance

NEUROLOGICAL
☐ Fainting
☐ Seizures
☐Muscle Weakness
☐ Numbness/tingling
☐ Loss of Memory
☐ Paralysis

URINARY
☐ Frequency at night
☐ Painful Urination
☐ Incontinence
☐ Kidney Stones
☐ Frequent Infections

REPRODUCTIVE
Please fill out the appropriate information for your body

☐ Breast tenderness
☐ Breast lump
☐ Endometriosis
☐ Menopausal symptoms
☐ Hernia
Age of 1st menses _____
Length of cycle _____

☐ Testicular pain
☐ Testicular lump
☐ Spotting
☐ Genital sores
☐ Painful/heavy menses
Age of last menses _____
Date of last pelvic exam _____

☐ Concerns w/ sexual function
☐ Concerns w/ fertility
☐ History of STIs
☐ Ovarian or uterine cysts
☐ Hot flashes
☐ Abnormal discharge

Do you currently use contraception? Yes/No Type _____
Are you sexually active? Yes/No

Is there anything else you would like us to know in order to serve you better? _____

_____

_____

_____

_____

_____

_____

_____

_____

Conditions Check (✓) conditions you currently have or have ever had in the past.

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding disorders
☐ Breast lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical dependency
☐ Chicken pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart disease
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High cholesterol
☐ HIV positive
☐ Kidney disease
☐ Liver disease
☐ Measles
☐ Migraines
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Psychiatric care
☐ Rheumatic fever
☐ Scarlet fever
☐ Sexually transmitted infection
☐ Stroke
☐ Suicide attempt
☐ Thyroid problems
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Vaginal infections

Medications List medications and supplements you are currently taking.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name _____

Allergies

Allergies

_____
_____
_____
_____
_____
_____
_____
_____
_____

Phone _____

Primary Care Doctor Name_____ Phone _____

Consent for Treatment:

I understand that my care as a patient at MWHC is directed by supervising staff physicians, licensed acupuncturists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care, as well as volunteer staff physicians who may be called upon for the purpose of consulting.

I recognize that MWHC is a teaching institution. I agree that persons who are students and resident physicians may participate in my care as part of the educational programs of the institution. I may be contacted by MWHC physicians for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at MWHC in any way.

I have fully read and understand the above agreements and authorizations.

_____ _____

Patient Signature Date

Statement of Financial Responsibility

I understand and agree to the following:

• Payment for services rendered is my responsibility as the patient or patient's responsible party.
• I am responsible for paying for all services, including lab tests, rendered at the time of service.
• How will you be paying for your visit? Please circle one:

Check Cash Debit/Credit Card (MasterCard or Visa only)

- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.
- If someone *other than the patient* is responsible for payment, please complete the following :

Name of responsible party (if other than the patient):

_____

Relationship to the patient: _____ Phone#: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Mercy & Wisdom Healing Center to release information necessary to secure payment.

_____ _____

Signature Date

Insurance Billing Procedures

If I am billing insurance for services rendered, I understand and agree to the following:

• I must submit invoices from MWHC to my insurance carrier for reimbursement.
• I authorize MWHC to release pertinent medical records related to billing. This release applies to support of the insurance billing process only.
• **I am responsible for any and all charges at the time of service.**

HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my protected health information by MWHC for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- MWHC has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by MWHC at the following address: 2 NW 3nd Avenue, Portland, Oregon 97209.
- I understand that while MWHC may honor these requests, they are not required by law to do so.
- I am aware that MWHC reserves the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, MWHC will make available a revised Notice of Privacy Practices for my review.

Alternative Method Of Communication Request:

As a courtesy, it is MWHC´s policy to call your home on the day prior to your scheduled appointment to remind you of your appointment time. We may leave a reminder message on your voicemail or with a person answering the phone – no personal health information will be disclosed.

☐ I agree with MWHC's standard method of communication.

☐ Or, please change as follows:_____

☐ Please contact me at the following telephone number:_____

☐ I prefer not to receive reminder calls.

We require at least 24 hours advance notice for cancelling appointments.

_____ _____

Patient or Responsible Party Signature Date

MERCY & WISDOM
COMMUNITY HEALTH CLINIC

A 501(c)3, non-profit, organization
Tel: (503) 227-1222 Fax: (503) 227-1555
8401 SE Powell Blvd.
Portland, OR 97266

CANCELLATION/NO SHOW POLICY

A doctor/patient relationship is built on mutual trust and respect. As such, strive to be on time for your scheduled appointments and we ask that you give us the courtesy of a call when you are unable to keep your appointment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If it is necessary to cancel or reschedule your appointment, we require that you notify us at least **24 hours in advance**.

1. 1st Missed Appointment: We'll call and offer to reschedule your appointment.
   *You will be charged a missed appointment fee of $20**
2. 2nd missed Appointment: We'll call and offer to reschedule your appointment.
   *You will be charged the full fee of your scheduled appointment**

Late for Scheduled Appointment
If you are more than 15 minutes late for your appointment, you will have to reschedule. If there is no one waiting, it will be up to the discretion of the doctor whether they will see you.

Account Balances
We will require that patients with outstanding balances pay their full account prior to receiving further services by our clinic.

To cancel appointments within 24 hours of your appointment, please call (503) 227-1222 or e-mail us at contact@mercyandwisdom.org. Thank you for your understanding and cooperation.

* Balances for missed appointments will not be covered by your insurance.

I have read and will comply with the cancellation/no show policy.

Name _____

Signature _____ Date _____