Medical Clinic
18144 Seco Street |PO Box 535
Jamestown Ca 95327
P. 209-984-4820 | F. 209-984-4825

Wellness Center
18158 Main St
Jamestown Ca 95327
P. 209-782-6446 | F. 209-984-9169

Red Feather Clinic
18232 Smoke St
Jamestown Ca 95327
P. 209-782-8625 | F. 209-984-9240

Please Select the location(s) you are requesting

☐ **Medical Clinic**
Primary Care
Hep C

☐ **Wellness Center**
Counseling
Psychiatry

☐ **MAT Acupuncture Clinic**
Addiction Treatment
Acupuncture

Patient Information

Last Name: **First Name:** **Middle:**			**Preferred Name:**
Gender: ( ) M ( ) F	**Date of Birth:** _____/_____/_____	**Marital Status:**	**Race:**
Email Address:		**Social Security # (SSN):** _____/_____/_____	
Home Phone Number: ( ) -		**Cell phone Number:** ( ) -	

Mailing Address:			**Physical Address:** (*if different from physical*)		
Address:			**Address:**		
City:	**State:**	**Zip:**	**City:**	**State:**	**Zip:**
Home Phone number:			**Cell phone Number:**		
Emergency Contact:		**Relationship:**	**Phone Number:**		

Guarantor Information (*Complete only if patient is a minor*)

Parent/Guardian Name:	**Relationship:**	**Date of Birth:** _____/_____/_____	**Phone Number:** ( ) -

Employer Information

Employer:	
Address:	**Phone Number:**

Insurance Information

Primary Insurance:		**Policy ID #:**
Name of Policy Holder (subscriber):	**DOB:** ___/___/___	**Group #:**
Secondary Insurance:		**Policy ID #:**
Name of Policy Holder (subscriber):	**DOB:** ___/___/___	**Group #:**

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I, the undersigned, am requesting health care services from the personnel at Mathiesen Memorial Health Clinic. I consent to exams, tests, immunizations, and treatment deemed necessary for my health. I hereby authorize the release of any information, including diagnosis of medical condition, for the purpose of payment by my insurance carrier. I affirm that the statements are true and correct to the best of my knowledge. I authorize the release of any information required by my insurance company to process claims. I further authorize assignment of benefits directly to Mathiesen Memorial Health Clinic. I understand that in the event the insurance information is not complete and correct, or if my insurance fails to make payment, I will be financially responsible for services rendered.

_____
Printed Name

_____ _____
Signature of Patient/Parent/Guardian Date

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Medical History

What is the main reason you are looking for a Medical Provider?

_____

_____

_____

Recent and past Medical Providers (last 3 years):

_____

_____

_____

_____

Chronic and ongoing Medical issues	Brief description, additional comments

Are you currently or have you in the past seen a Behavioral Health Professional Yes___No____	
Behavioral Health Providers Name & Number	**Medication prescribed by this provider**

Past Medical Issues	How resolved, additional comments

Allergies	What Happens? Allergic/Adverse/Bad Reaction

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Please list all medication including dose, amount and prescribing physician

Medication	Dose (usually mg.)	How many x A day?	Who prescribed it, when started	Reason taken

Non-prescription medicine Herbs/Supplements	Dose if known	How many daily	Reason taken

Alcohol - I drink alcohol | Yes: _____ No: _____ Pattern of Use: _____

Alcohol has caused me problems or my family complains about my drinking | Yes:_____No:_____

I no longer drink because: _____

Drugs - I use drugs | Yes: _____ No: _____ Pattern of Use: _____

I have used injection drugs or cocaine straws in the past (risk of hepatitis C) Yes_____No_____

Drugs have been a problem for me in the past_____

Signature and date REQUIRED

Signature_____Date: _____/_____/_____