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

Mathiesen on Main
18268 Main St
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P. 209-630-2772 | F. 209-984-9240

Please select the location(s) you are requesting below:

Medical Clinic	Wellness Center	Red Feather Clinic	Mathiesen on Main
☐ *Primary Care*	☐ *Counseling*	☐ *Addiction Treatment*	☐ *Same Day / Walk in*
☐ *Hep C*	☐ *Psychiatry*	☐ *Acupuncture*	
☐ *Dermatology*		☐ *Pain Management*	

Patient Information:

Last Name: _____ First Name: _____Middle: _____

Preferred Name: _____ Date of Birth:_____/_____/_____

Gender: ☐ M ☐ F ☐ M to F ☐ F to M ☐ other Race: _____ Marital Status: _____

Social Security # (SSN): _____ Email Address: _____

Home Phone #: Cell Phone #:

Emergency Contact: _____ Relationship:_____ Phone Number:_____

Tribal Affiliation: _____

Mailing Address:

Address: _____City: _____ State: _____ Zip: _____

Physical address (*if different from mailing address)***:**

Address: _____City: _____ State: _____ Zip: _____

Guarantor Information (*Complete ONLY if patient is a minor)***:**

Parent/Guardian Name: _____ Relationship: _____ Date of Birth:_____/_____/_____

Phone #:

Insurance Information:

Primary Insurance: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: ____/____/____ Group #: _____

Secondary Insurance: _____ Policy ID #: _____

Name of Policy Holder: _____ 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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Patient Medical History Form

Date:_____

Past Medical History: *(check all that apply)*

- ☐ Acid Reflux
- ☐ Alcohol or Drug Problem
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery/Vein problems
- ☐ Arthritis/Joint Problems
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Cancer
  Types
- ☐ Cataracts
- ☐ Colitis/Crohns
- ☐ COPD
- ☐ Chronic pain
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Esophagitis, ulcers
- ☐ Fractures
- ☐ Gallstone
- ☐ GERD
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Irritable bowel
- ☐ Kidney disease
- ☐ Kidney Stones
- ☐ Liver Disease/ Hepatitis
  Types _____
- ☐ Lung disease
- ☐ Migraines
- ☐ Mental Health Diagnosis
- ☐ MRSA
- ☐ Prostate Problems
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted diseases
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid diseases

Other diseases not listed above:_____

Hospitalizations/Significant injuries:_____

Surgery/Procedures History: *(check all that apply and please provide dates)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Colon/Rectal surgery
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart Surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
  - ☐ Pacemaker
- ☐ Hysterectomy
  - ☐ Complete ☐ Partial
- ☐ Hernia
- ☐ Joint replacement/Orthopedic surgery
- ☐ Kidney surgery
- ☐ Organ Transplant
- ☐ Prostate surgery
- ☐ Thyroidectomy
- ☐ Sinus surgery
- ☐ Spinal Surgery
- ☐ Tonsils and/ or adenoids
- ☐ Tubal Ligation

☐ Gastric Bypass: Type _____

☐ Vasectomy

Other surgery not listed above:_____

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

Please list the names and contact information of other practitioners you have or are currently seeing:

Are you currently or have you in the past seen a Behavioral Health Professional? Yes☐ No☐

If yes, please list the providers and number:

Medication List:

Please list **all *prescription*** and ***non-prescription*** medications. This includes vitamins, herbal medicine, supplements, birth control pills, inhalers and over the counter medications.

Medication	Dosage	How often	Disease or Reason	Prescribed by (*if applicable)*

Allergies or reactions:

Medication/Food/Environmental	Reaction	Medication/Food/Environmental	Reaction
1.		**2.**	
3.		**4.**	
5.		**6.**	

Preferred Pharmacy:_____

Secondary pharmacy / Mail order: _____

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Family History

Please check ALL that apply to each Family Member

	MOM	DAD	BROTHER	SISTER	BROTHER	SISTER	Maternal/Paternal Grandmother	Maternal/Paternal Grandfather
Alive and Well								
Deceased, Reason & Age								
ADD/ ADHD								
Alcoholism/ Addiction								
Allergies								
Alzheimer's Disease								
Asthma								
Blood Disease								
CAD/ Heart Attack								
CAD under 60yrs/ old								
Cancer								
Breast								
Colon								
Lung								
Prostate								
Other/ Unknown								
CVA/ Stroke								
Depression								
Suicide								
Developmental Delay								
Diabetes								
Eczema								
Hearing Deficiency								
High Cholesterol								
Hypertension								
Irritable Bowel Disease								
Learning Disability								
Mental Illness Type:								
Migraines								
Obesity								
Osteoporosis								
Blood Clots in legs								
Kidney Disease								
Seizure disorder								
Other								

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Social History:

Do you live: Alone ☐ with Spouse or Partner ☐ with Family ☐ Other

Who do you rely on for support and help? _____

Current Job Occupation: _____

Are you currently an active member in the military or a Veteran? ☐ Yes ☐ No Branch: _____

Do you smoke? ☐ Currently ☐ Past ☐ Never Total number of years: _____ Date Quit: _____

Cigarettes per day/ packs per day: _____ Vapes: _____ Marijuana: _____

If you do smoke, are you interested in quitting? ☐ YES ☐ NO

Other nicotine use ☐ YES ☐ NO _____

Have you had exposure to second hand smoke? ☐ YES ☐ NO

Any recreational drug use? ☐ YES ☐ NO

Drug of choice : _____

Route : ☐ smoke ☐ snort ☐ inject

Have drugs been a problem in the past? _____

Have you been screened for the following: ☐ HIV ☐ HCV ☐ Other STD

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? _____

How many caffeinated beverages per day? _____ ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements

Do you exercise regularly? ☐ YES ☐ NO If so how many times per week? _____

Type of exercise: _____

Do you feel safe in your home? ☐ YES ☐ NO

0ver the last two weeks have you been bothered by:

Little interest or pleasure in doing things? ☐ No ☐ Yes Feeling down, depressed or hopeless? ☐ No ☐ Yes

How many hours of sleep do you get per night? _____ Do you wake feeling well rested? ☐ YES ☐ NO

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Preventative Care:

Date of last Colon/ Cancer Screening:_____

Have you had a bone density (DEXA) exam? ☐YES ☐NO Date:_____

Date of last eye exam:_____Date of last dental exam:_____

Immunizations	Date & Where	Immunizations	Date & Where
Tetanus		Hepatitis A	
Influenza/Flu		Hepatitis B	
Pneumonia		Shingles	
Covid-19: ☐ Moderna ☐ Janssen ☐ Pfizer	*Date of Booster if applicable* 1. 2. 3. 4.	HPV	

For our FEMALE patients only:

Date of last menstrual period:_____

Do you have a Gynecologist: ☐ YES ☐ NO If yes, Gynecologist name:_____

Date of last PAP test:_____Date of last mammogram: _____

Have you gone through menopause? ☐ YES ☐ NO

Menstrual problems: ☐ Irregular ☐ Heavy ☐ Change in frequency

Number of pregnancies:_____ Number of live births:_____

Current birth control method:_____

For our MALE patients only: Date of last PSA test:_____ Where: _____

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NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic (MMHC). Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by asking for one at the clinic or contacting our Privacy Officer at 209-984-4827.

If you have any questions about our Notice of Privacy Practice, please contact:

Privacy Officer
P.O. Box 535
Jamestown, Ca 95327
Phone: 209-984-4827

I acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic.

Patient Name : _____

Patient Signature : _____ Date : _____
Patient/Parent/Conservator Guardian

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PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Do you give our office permission to discuss your medical/financial information with a person(s)?

Yes: ☐ No: ☐ (*if yes, please provide their name and relationship below*)

NAME:	**RELATIONSHIP:**	**PHONE NUMBER:**

May we leave personal medical information on your answering machine/voicemail: Yes ☐ No: ☐

Patient Name: _____

Patient Signature_____ Date: _____/_____/_____

Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why it was not obtained.

Patient reason for refusing or inability to sign acknowledgement: