MATHIESEN MEMORIAL HEALTH CLINIC

"Close to home…far from ordinary"

Welcome to Mathiesen Memorial Health Clinic!

Mission: To improve the health and wellness of our community as the premier place to give and receive care that embraces the balance of mind, body, and spirit.

Vision: Established by the Chicken Ranch Rancheria of Me-Wuk Indians of California, Mathiesen Memorial Health Clinic is close to home, yet far from ordinary. We serve with kindness, integrity, compassion, collaboration, and strive for excellence to maximize individual and community health and wellness.

Locations:

Main Clinic

We take pride in having a happy, well-trained and courteous staff. These are just a few of the services we offer; please feel free to contact us with any medical concerns you may have.

Services: Routine Office Visits, Women's Health, Family Planning, Pediatric Care, Dermatology**, Hepatitis C Treatment**, Comprehensive Liver Care, Diabetic Treatment, Smoking Cessation Treatment, and lab draws & interpretation. (**referral required)

18144 Seco Street Jamestown, CA 95327 Phone: (209) 984-4820 Fax: (209) 984-4825

Red Feather Clinic

Serving our community to prevent and heal addiction. No referral needed, walk-ins welcome!

Services: Medication Assisted Treatment for Substance Use Disorder, Substance Use Disorder Counseling, Acupuncture Therapy, Pain Management**, Care Coordination, and NARCAN Available. (**referral required)

18232 Smoke Street Jamestown, CA 95327 Phone: (209)782-8625 Fax: (209)984-9240

Wellness Center

Our Wellness Center uses an integrative approach that helps patients to heal by taking the entire life experience into consideration.

Services: Individual, Family, and Child therapy, along with Therapeutic Yoga (virtual), Hypnosis, EMDR, Art therapy, and Psychological testing.

18158 Main St. Jamestown Ca 95327 Phone: (209)782-6446 Fax: (209)984-9169

Same Day Walk In Clinic

We provide treatment for illnesses and injuries that do not require a visit to the emergency room but need timely attention. Same day appointments available. Walk-in's welcomed!

Services: COVID testing/treatment site, Ear & Sinus Infections, Sports Physicals, Cough/Cold & Flu Symptoms, Urinary Tract Infections, Pink Eye, Rashes, Minor Sprains, STD Screening, and other non-life-threatening conditions or illnesses.

18268 Main St. Jamestown , CA 95327 Phone: (209)630-2772 Fax: (209)984-9085

Dental Clinic

Here to serve and support our communities' dental needs. We offer services to all and accept Medi-Cal, Humana, out-of-network insurance, and offer a cash pay discount for the non-insured.

Services: Cleanings, Exams, Fillings, Simple Extractions, Root Canals, Crowns & Bridges, Dentures & Partials, and Digital X-rays & Impressions.

940 Sylva Lane #K2 Sonora, CA 95370 Phone: (209)536-8600 Fax: (209)536-8606

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Date:_____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name:

Preferred Name: Date of Birth: / /

Gender: ☐ M ☐ F Race:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone #: ( ) - Cell Phone #: ( ) -

Mailing Address: City: State: Zip:

Tribal Affiliation:

Have you (the adult) or the patient (the child) had any of the following:
☐ A cough that's lasted longer than three weeks
☐ A cough that produces blood
☐ Active Tuberculosis
Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

DENTAL INSURANCE

Insurance: Policy ID #:

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

PATIENT'S DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No ☐ ? If yes, where?

Is this the patient's first visit to a dentist? ☐ Yes ☐ No ☐ ? If no, when was the patient's last dental exam? / /
What was done at that appointment?

When was the last time the patient had dental x-rays taken?

Has the patient had any problems with dental treatment in the past? ☐ Yes ☐ No ☐ ?
If yes, please describe what happened:

Has the patient had any problems with teeth coming in or losing teeth? ☐ Yes ☐ No ☐ ?

Does the patient use fluoride toothpaste when brushing teeth? ☐ Yes ☐ No ☐ ?
How often are the patient's teeth brushed? # Time(s) per At what time(s) of day are the teeth brushed?

Has the patient ever worn braces or other orthodontic appliances? ☐ Yes ☐ No ☐ ?

Has the patient ever had a serious injury to the head, mouth, or teeth? ☐ Yes ☐ No ☐ ?
If yes, please describe what happened and when:

Does the patient play any contact sports or participate in active recreational activities? ☐ Yes ☐ No ☐ ?
If yes, please describe those activities here:

Is your home water supply fluoridated? ☐ Yes ☐ No ☐ ?

What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well

Does the patient take fluoride supplements? ☐ Yes ☐ No ☐ ?

Does/did the patient use a pacifier or suck his/her thumb or fingers? ☐ Yes ☐ No ☐ ?
At what age did the patient stop breastfeeding? At what age did the patient stop bottle feeding?

Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

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PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Doctor's Name: _____ Phone Number: _____

Does the patient see any medical specialists? ☐ Yes ☐ No ☐ ? If yes, please explain:

Is the patient currently being treated for any condition(s) or illness(es)? ☐ Yes ☐ No ☐ ?
If yes, what is the illness and when did it start?

Has the patient ever had a serious illness? ☐ Yes ☐ No ☐ ?
If yes, what is the illness and when did it happen?

Has the patient ever been hospitalized? ☐ Yes ☐ No ☐ ? If yes, when and why?

Has the patient ever been given a general anesthetic? ☐ Yes ☐ No ☐ ?

Has the patient ever had a blood transfusion? ☐ Yes ☐ No ☐ ?

Does the patient experience excessive bleed when cut? ☐ Yes ☐ No ☐ ?

Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? ☐ Yes ☐ No ☐ ?
If yes, please explain why and provide the recommending doctor's name:

Has the patient been diagnosed with any physical, developmental, mental, or emotional conditions? ☐ Yes ☐ No ☐ ?
If yes, please explain:

Does the patient have any genetic (inherited) conditions? ☐ Yes ☐ No ☐ ? If yes, please explain:

Does the patient have any speech difficulties? ☐ Yes ☐ No ☐ ? If yes, please explain:

How you would describe the patient's eating habits?

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No ☐ ?

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past.

☐ ADD/ADHD	☐ Chicken Pox	☐ Hepatitis	☐ Seizures
☐ Alcohol/Drugs	☐ Chronic sinusitis	☐ HIV/AIDS	☐ Sexually transmitted infection
☐ Anemia	☐ Diabetes	☐ Immunizations	☐ Sickle Cell Anemia
☐ Arthritis	☐ Ear aches	☐ Kidney problems	☐ Thyroid issues
☐ Asthma	☐ Epilepsy	☐ Liver problems	☐ Tobacco/Vaping
☐ Bladder problems	☐ Fainting	☐ Measles	☐ Tuberculosis
☐ Bleeding disorders	☐ Growth problems	☐ Mononucleosis	☐ Other: _____
☐ Bone/joint issues	☐ Hearing problems	☐ Mumps	_____
☐ Cancer	☐ Heart Issue	☐ Pregnancy (teens)	_____
☐ Cerebral Palsy	☐ Heart Murmur	☐ Rheumatic fever	

MEDICATIONS & ALLERGIES

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications? ☐ Yes ☐ No ☐ ?
If yes, please list them here: _____

Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?
☐ Yes ☐ No ☐ ? If yes, please list those medications and the reaction: _____

Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.? ☐ Yes ☐ No ☐ ?
If yes, please describe the allergy and the reaction: _____

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

_____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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CONSENT TO TREAT

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 Date of Birth

_____ ____/____/____

Signature of Patient/Parent/Guardian Date

Cancellations: If you need to reschedule, please call at least 24 hours in advance. Two consecutive no shows, or three in six months, can be grounds for discharge from our practice. Phone number 209-536-8600

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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: _____ Date of Birth: _____/_____/_____

Patient Signature: _____ Date: _____/_____/_____

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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: _____ Date of Birth: _____/_____/_____

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

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:

_____

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MINOR TREATMENT CONSENT FORM

_____

Date form completed

_____ _____

Printed Name of Minor Patient Date of Birth

I am the parent/guardian of _____ (legal name of patient). I have the legal right to consent to medical treatment for this minor patient.

I authorize the following individual(s)

_____ _____ _____

Name of Person Authorized Date of Birth Relationship to minor patient

_____ _____ _____

Name of Person Authorized Date of Birth Relationship to minor patient

to bring the minor patient to his or her medical or dental appointments and consent to medical or dental treatment which is deemed necessary by the treating provider. The treatment may include, but is not limited to, laboratory procedures, x-ray examinations, and medical or dental treatment, done at Mathiesen Memorial Health Clinic. (MMHC)

Parent/Guardian Signature: _____ Date: _____

VERBAL/PHONE AUTHORIZATION – MMHC STAFF USE ONLY

The parent/guardian hereby consents to medical treatment that is deemed necessary by the treating provider. The treatment may include, but is not limited to, laboratory procedures, x-ray examinations, and medical or dental treatment, done at Mathiesen Memorial Health Clinic. (MMHC)

I have obtained telephone consent to provide medical or dental care for the minor patient after speaking with the patient's parent/guardian: _____.

Printed name of parent/guardian

_____ _____ _____

Name of Person Authorized Date of Birth Relationship to minor patient

MMHC Staff obtaining authorization:

_____ _____ _____

Print MMHC Staff Name MMHC Staff Signature Date

Updated 8/06/2025