



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
Jamestown Ca 95327
P. 209-630-2772 | F. 209-984-9240

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

Medical Clinic

- Primary Care
- Hep C
- Dermatology

Wellness Center

- Counseling
- Psychiatry

Red Feather Clinic

- Addiction Treatment
- Acupuncture

Mathiesen on Main

- 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)*

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

Other diseases not listed above: _____

Hospitalizations/Significant injuries: _____

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

- | | | |
|-----------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Joint replacement/Orthopedic surgery |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Bypass | <input type="checkbox"/> Kidney surgery |
| <input type="checkbox"/> Blood vessel surgery | <input type="checkbox"/> Heart valve surgery | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Arteries | <input type="checkbox"/> Angioplasty (balloon) | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Veins | <input type="checkbox"/> Stents | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Colon/Rectal surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> Dental surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Spinal Surgery |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Complete <input type="checkbox"/> Partial | <input type="checkbox"/> Tonsils and/ or adenoids |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Gastric Bypass: Type _____ | | <input type="checkbox"/> 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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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:



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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 EnergySupplements

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

Over 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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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: <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> 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 NOMenstrual 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 : _____

Patient/Parent/Conservator Guardian

Date : _____