MATHIESEN MEMORIAL HEALTH CLINIC

"Close to home…far from ordinary"

CHECKLIST FOR ALL NEW PATIENTS

- ☐ Photo ID
- ☐ Insurance card
- ☐ Medications
- ☐ New patient paperwork
- ☐ Immunization record

Minors need to additionally bring

- ☐ Birth Certificate
- ☐ Photo ID if available
- ☐ Court documents identifying parental rights/custodian if applicable
- ☐ Treatment consent form

MATHIESEN MEMORIAL HEALTH CLINIC

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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 community's 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

MATHIESEN MEMORIAL HEALTH CLINIC

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Patient Information:

Patient Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____Date of Birth:_____ Social Security # (SSN):_____

Preferred Language: _____ Tribal Affiliation: _____

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

Home Phone #: _____ Cell Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Minors Email Address: _____

Parents Email Address: _____

Mailing Address:

Address: _____ City: _____ State: _____ Zip: _____

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

Address: _____ City: _____ State: _____ Zip: _____

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

Mother/Guardian Name: _____Relationship:_____

Date of Birth:_____ Phone #: _____ ID Number: _____

Father/Guardian Name: _____ Relationship:_____

Date of Birth:_____ Phone #: _____ ID Number: _____

☐ Please provide court documentation if guardianship is other than biologic mother/father on birth certificate.

Insurance Information:

Primary Insurance: _____ Policy ID #: _____

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

Secondary Insurance: _____ Policy ID #: _____

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

Prescription Coverage: _____ Policy ID #: _____

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

MATHIESEN MEMORIAL HEALTH CLINIC

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What services are you interested in receiving? (please note some services require a referral, see front page for more info)

_____

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

Medical provider: _____

Mental Health provider: _____

Dentist: _____

Preferred Pharmacy: _____

Secondary pharmacy / Mail order: _____

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.**	

MATHIESEN MEMORIAL HEALTH CLINIC

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Patient Medical History Form

Past Medical History: (check all that apply)

- ☐ Acid Reflux/GERD
- ☐ Alcohol/drug use disorder
- ☐ Allergy problems
- ☐ Anemia
- ☐ Anticoagulation therapy
- ☐ Anxiety
- ☐ Artery/Vein problems
- ☐ Arthritis/Joint problems
- ☐ Asthma
- ☐ Autoimmune Disease

Specify:_____

- ☐ Blood Clots

Location:_____

- ☐ Bleeding problems
- ☐ Cancer

Specify:_____

- ☐ Cataracts
- ☐ C. Difficile
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ COPD
- ☐ Chronic Pain

Specify:_____

- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Esophagitis, Ulcers
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gallstone
- ☐ Glaucoma
- ☐ Heart Disease

Specify:_____

- ☐ Heart valve problems
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease

Specify:_____

- ☐ Lung Disease
- ☐ Pancreatitis
- ☐ Primary Biliary Cholangitis
- ☐ Migraines
- ☐ Mental health diagnosis
- ☐ MRSA
- ☐ Prostate problems
- ☐ Psoriasis
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infection
- ☐ Sleep Apnea
- ☐ Stroke/CVA
- ☐ TB
- ☐ Thyroid diseases
- ☐ Ulcerative Colitis

Other diseases or disorders not listed above:

Preventative Care:

Last Colon Cancer Screening: ☐ Stool test ☐ Cologuard ☐ Colonoscopy Date: _____

Have you had a bone density (DEXA) exam? ☐ Yes ☐ No Date:_____

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

Are you Currently sexually active? ☐ Yes ☐ No With: ☐ Men ☐ Women ☐ Both

MATHIESEN MEMORIAL HEALTH CLINIC

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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: _____ History of Abnormal Pap? ☐ Yes ☐ NO 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:

Last prostate exam: _____ Last PSA: _____

Urinary problems: ☐ Yes ☐ No Erectile dysfunction ☐ Yes ☐ No

Please list your immunizations or attach immunization card

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

MATHIESEN MEMORIAL HEALTH CLINIC

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

	Reason for surgery	Approximate date
Appendix		
Bladder Suspension		
Blood vessel surgery		
Bowel Surgery		
Breast Surgery		
Dental surgery		
Eye surgery		
Gallbladder		
Gastric Bypass: Type		
Hepatobiliary Surgery		
Heart Surgery: Type		
Hysterectomy: Reason: ☐Complete ☐Partial		
Hernia Location:		
Joint replacement/Orthopedic surgery		
Kidney surgery		
Organ Transplant Type:		
Prostate surgery		
Thyroidectomy		
Sinus surgery		
Spinal Surgery		
Tonsils and/ or adenoids		
Tubal Ligation/Vasectomy		
Other		

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Family History: Please fill out as complete as possible

	Mother	Father	Brother	Sister	Brother	Sister	Son	Daughter	G.Mother Mom	G.Mother Dad	G.Father Mom	G.Father Dad
Alive and Well												
Deceased, Reason & Age												
ADD/ADHD												
Alcoholism/Addiction												
Allergies												
Alzheimer's Disease												
Anemia												
Anxiety												
Asthma												
Behavioral health/Mental disorder (Type)												
Birth/Congenital Defects												
Blood Clots												
Bone/joint problems												
Bleeding problems/Hemophilia												
CAD/ Heart Attack												
CAD under 60yrs old												
Cancer: Specify below												
Breast												
Colon												
Lung												
Prostate												
Other/ Unknown												
Celiac disease												
Colon Polyps												
CVA/ Stroke												
Depression												
Suicide												
Developmental Delay												
Diabetes												
Eczema												
Hearing Deficiency												
High Cholesterol												
HIV/AIDS												
Hypertension												
Inflammatory bowel disease: Crohn's/Ulcerative colitis												
Irritable Bowel Syndrome												
Kidney problems												
Learning Disability												
Liver Disease												

MATHIESEN MEMORIAL HEALTH CLINIC

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	Mother	Father	Brother	Sister	Brother	Sister	Son	Daughter	G.Mother Mom	G.Mother Dad	G.Father Mom	G.Father Dad
Lung Problems												
Migraines												
Muscular disorder												
Obesity												
Osteoporosis												
Seizure disorder												
Sickle Cell Anemia												
SIDS												
Skin disorder												
Thyroid problems												
Tuberculosis												
Other												

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 smoked: 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 current or past? ☐ Yes ☐ No

Drug of choice: _____ Route: ☐ Smoke ☐ Snort ☐ Inject Date Quit:_____

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 Drinks

Do you exercise regularly? ☐ Yes ☐ No If so, how many times per week? _____

MATHIESEN MEMORIAL HEALTH CLINIC

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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? ☐ Yes ☐ No

Feeling down, depressed, or hopeless? ☐ Yes ☐ No

How many hours of sleep do you get per night? Do you wake feeling well rested? ☐ Yes ☐ No

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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

MATHIESEN MEMORIAL HEALTH CLINIC

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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 : _____

MATHIESEN MEMORIAL HEALTH CLINIC

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Missed Appointment Policy

Patient Name: _____ Date of Birth:

Thank you for choosing Mathiesen Memorial Health Clinic (MMHC) as your health care provider. To ensure the highest quality of care for you and all our patients, we ask that you adhere to our guidelines concerning missed appointments. MMHC provides appointment reminders as a courtesy, but we kindly ask that you take responsibility for keeping or canceling it as needed. We require at least 24-hour notice to cancel or reschedule your appointment. This allows us to offer your cancelled appointment slot to another patient in need of care.

While MMHC strives to minimize missed appointments, we will allow up to three missed appointments in a six-month period. An appointment is considered missed under any of the following circumstances:

- Patient fails to show up to a scheduled appointment.
- Patient provides fewer than 24 hours' notice to cancel or reschedule an appointment.
- Patient who arrives more than 10 minutes past their scheduled appointment time.
  **For dermatology and same-day appointments, the grace period is reduced to 5 minutes*.
- Wellness Center:
  - New patient – grace period is 15 minutes
  - Established patients – grace period is 30 minutes

Patients who miss three of more consecutive appointments within a rolling six-month period may be dismissed from care at the clinic's discretion.

_____ _____

Signature Date

_____

Printed Name

Relationship to Patient (if applicable): _____

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PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

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

☒ Yes ☐ No (If yes, please provide additional information below)

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

May we leave personal medical information on your answering machine, voicemail, email, or text message: ☐ Yes ☒ No

Patient Name: _____ Date of Birth:

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 acknowledgement, and the reason why it was not obtained. Patient reason for refusing or inability to sign acknowledgement:

_____

Staff Use- Clinic accepting Patient Authorization form:

☐ Primary Care
☐ Dental Clinic
☐ Walk-In Clinic
☐ Red Feather Clinic
☐ Wellness Center
☐ Acupuncture

Patient Label