



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 check the specific care you are seeking below (can be more than one):

Medical Clinic

- Primary Care
- Hep C/Gastroenterology
- Dermatology

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 #: () _____ - _____ Cell Phone #: () _____ - _____

Emergency Contact Name: _____ Relationship: _____ Phone: () _____ - _____

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 Number: () _____ - _____

Insurance Information:

Primary Insurance: _____ Policy ID #: _____

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

Secondary Insurance: _____ Policy ID #: _____

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



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

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

**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

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"/> Chronic pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression, Anxiety | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Artery/Vein problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Recurrent skin infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Esophagitis, ulcers | <input type="checkbox"/> HIV | <input type="checkbox"/> Recurrent UTI |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sexually transmitted |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver disease/Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lung disease | <input type="checkbox"/> TB |
| | | | <input type="checkbox"/> Thyroid diseases |

Other diseases not listed above: _____

Hospitalizations/Significant injuries: _____

Surgery/Procedures History: *(check all that apply)*

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Heart Surgery: | <input type="checkbox"/> Joint replacement/Orthopedic |
| <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"/> Tonsils and/or adenoids |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Complete <input type="checkbox"/> Partial | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Vasectomy |

Other surgery not listed above: _____



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

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

Please list the names 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 name 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: _____

**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

Family History:

Family Member	Age(s)	Living	Cause of Death
Father		Y/N	
Mother		Y/N	
Brother(s) #:		Y/N	
Sister(s) #:		Y/N	

Diseases in the family: (check all that apply)

- | | | | |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer: | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Addiction problems | <input type="checkbox"/> Breast | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Colon | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease |
| | <input type="checkbox"/> Prostate | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental Illness |
| | <input type="checkbox"/> Other | | |

Social History:

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

Who do you rely on for support and help? _____

Do you smoke? Currently Past Never _____ packs/day for _____ years Date Quite: _____

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

Other nicotine use: YES NO If yes, what type/form: _____

Exposure to secondhand smoke? YES NO

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

Any recreational drug use? YES NO

Type: _____

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

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

**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

Preventative Care:

Date of last Colon and Rectal Screening: _____ Where: _____

Have you had a bone density (DEXA) exam? YES NO

Date: _____ Where: _____

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

Immunizations	Date	Immunizations	Date
Tdap		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles/Zoster	
Covid-19: <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> Pfizer	*Include date of booster is 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: _____ Where: _____

Date of last mammogram: _____ Where: _____

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: _____

Date of last rectal exam: _____ Where: _____

**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

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 : _____



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

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:
