MATHIESEN MEMORIAL HEALTH CLINIC

"Close to home…far from ordinary"

CHECKLIST FOR NEW PEDIATRIC PATIENTS

- ☐ Photo ID for parent or guardian
- ☐ Insurance card
- ☐ Medications
- ☐ New patient paperwork

Minors need to additionally bring

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

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 #: _____

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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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PREGNANCY AND BIRTH HISTORY

Place of Birth: Location: ☐ Hospital ☐ Home Obstetrician: Mother's Age at Birth:

During pregnancy, Did Mother have any of these conditions?

☐ Yes ☐ No Alcohol Use
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Prescription drug use Type: _____
☐ Yes ☐ No Non-prescription drug use Type: _____
☐ Yes ☐ No Edema (swelling)
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Tobacco use
☐ Yes ☐ No Other illness/infection:

Infant Birth Health

Birth weight and length: _____
Gestational age: _____
Infant discharge weight: _____
Age (days) when discharged: _____
Delivery method? ☐ Vaginal ☐ C-section
Birth complications? _____
APGAR Score if known: _____
Was the child breast fed? ☐ Yes ☐ No Until what age? _____

CHILD HEALTH HISTORY

Please check current and/or past history

Current	Past	General	Current	Past	Gastrointestinal	Current	Past	Hearing/Speech
☐	☐	Anemia	☐	☐	Poor appetite	☐	☐	Difficulty hearing
☐	☐	Anxiety	☐	☐	Bloody/dark stools	☐	☐	Earache
☐	☐	Chicken Pox	☐	☐	Constipation	☐	☐	Ear infections
☐	☐	Chills			Diarrhea	☐	☐	Speech problems
☐	☐	Depression	☐	☐	Excessive hunger			**Dental**
☐	☐	Dizziness	☐	☐	Excessive thirst	☐	☐	Bleeding gums
☐	☐	Fainting	☐	☐	Reflux/GERD	☐	☐	Grinding teeth
☐	☐	Headache	☐	☐	Hepatitis TYPE:_____			Last dental visit:
☐	☐	Loss of sleep	☐	☐	Rectal bleeding			**Brusing Teeth**
☐	☐	Mood swings	☐	☐	Stomachaches			How often brushing?
☐	☐	Nervousness	☐	☐	Vomiting	☐	☐	Sensitivity to hot/cold
☐	☐	Numbness	☐	☐	Worms	☐	☐	Thumb sucking
☐	☐	Seizures			**Genito-Urinary**			**Nose/Throat/Chest**
☐	☐	Sweating	☐	☐	Bed wetting	☐	☐	Asthma
☐	☐	Tiredness	☐	☐	Blood in urine	☐	☐	Bronchitis
☐	☐	Weight loss/gain	☐	☐	Vaginal/penile discharge	☐	☐	Difficulty breathing
☐	☐	Weakness			**Eyes**	☐	☐	Frequent colds
		Cardiovascular	☐	☐	Eye irritation	☐	☐	Hoarseness
☐	☐	Breathing problems	☐	☐	Headaches	☐	☐	Mouth-breathing
☐	☐	Chest pain	☐	☐	Vision problems	☐	☐	Persistent cough
☐	☐	Irregular heartbeat			**Skin**	☐	☐	Pneumonia
		Muscle/Joint/Bone	☐	☐	Bruise easily	☐	☐	Sinus problems
☐	☐	Broken bones/sprains	☐	☐	Change in moles	☐	☐	Sore throat
☐	☐	Poor coordination				☐	☐	Strep throat
☐	☐	Posture problems	☐	☐	Itching	☐	☐	Tonsil infections
		Congenital anamolies	☐	☐	Rash	☐	☐	Wheezing
		Please List:	☐	☐	Scars	☐	☐	Whooping Cough
☐	☐		☐	☐	Sores that won't heal			
☐	☐		☐	☐	Birth marks			

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HOSPITALIZATIONS/SURGERIES

Reason	Date	Hospital	City	State

CHILD SAFETY INVENTORY

☐ Yes	☐ No	Smoke alarms in house	☐ Yes	☐ No	Exposure to tobacco smoke
☐ Yes	☐ No	Car seat-seatbelt use	☐ Yes	☐ No	Household cleaners are out of reach
☐ Yes	☐ No	Syrup of Ipecac in home	☐ Yes	☐ No	Medicine is out of reach
☐ Yes	☐ No	Safety gate for stairs	☐ Yes	☐ No	Child knows how to swim
☐ Yes	☐ No	Know dangers of peeling paint in home	☐ Yes	☐ No	Know emergency numbers
☐ Yes	☐ No	Know dangers of pests (mice/rats) in home	☐ Yes	☐ No	Water heater below 120 degrees
☐ Yes	☐ No	Guns are in locked cabinet in home	☐ Yes	☐ No	Bicycle helmet used

Social History

With whom does the child live? _____

Does the child attend school or day care? ☐ Yes ☐ No If yes, where? _____

Does your child exercise regularly? ☐ Yes ☐ No What type of activity? _____

Do you and your child feel safe in your home? ☐ Yes ☐ No

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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												

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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												

NOTE: I understand that it's important for both the provider and the patient or his/her parent/guardian to talk honestly about the patient's health before being seen. I have answered all of the questions above completely and accurately. I understand that the provider and his/her staff need this information so the patient receives the right kind of 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 STAFF

Comments:

Reviewed by: _____ Date: _____

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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

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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