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, Eating Disorder Partnership, 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, Family PACT, 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

MATHIESEN MEMORIAL HEALTH CLINIC

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Date:_____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all the information we need in order to treat you.

PATIENT INFORMATION

Last Name: First Name: Middle Name:

Preferred Name: Date of Birth:

Gender: ☐ M ☐ F ☐ M to F ☐ F to M ☐ Other Race: Martial Status:

Social Security # (SSN): Email Address:

Home Phone #: Cell Phone #:

Mailing Address: City: State: Zip:

Emergency Contact: Relationship: Phone #:

Tribal Affiliation:

If you are completing this form for another person, what is your name and relationship to that person?
Name:_____ Relationship: _____
If executing this form as the patient's personal representative 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.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? What was done at that appointment?

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

Please mark an "X" in the box only if this applies to you.

Is it hard to open your mouth?..... ☐
Does it hurt to chew, bite, or swallow?..... ☐
Do your gums bleed when you brush or floss your teeth?..... ☐
Have you ever had periodontal (gum) treatments like scaling and root planning?..... ☐
Do you have, or have you ever had, any sores or growths in your mouth?..... ☐
Do you clench or grind your teeth?..... ☐
Does your jaw click, pop, or hurt?..... ☐
Do you have earaches or neck pains?..... ☐
Does dental treatment make you nervous?..... ☐
Have you ever experienced any of these sleep-related breathing disorders?..... ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had serious injury to your head or mouth?..... ☐
If yes, please describe what happened and when:
_____
Have you ever had problems with dental treatment in the past?..... ☐
If yes, please describe: _____
_____
Have you ever had a reaction to, or problem with, dental anesthesia?. ☐
If yes, please describe: _____
_____
Are you unhappy with your smile? .....☐
If yes, why? Please mark all that apply:
☐ Color of your teeth ☐ Shape of your teeth ☐ Position of your teeth
☐ Other, please describe: _____
_____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ..... ☐ Yes ☐ No ☐ ?
If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease?..... ☐ Yes ☐ No ☐ ?
Some commonly prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®). If yes, what medication are you taking?_____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... ☐ Yes ☐ No ☐ ?
Some commonly prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®), or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormone replacements**?..... ☐ Yes ☐ No ☐ ?

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?..... ☐ Yes ☐ No ☐ ?

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MEDICATIONS & OTHER PRODUCTS/SUBSTANCES CONTINUED

Do you use **vaping products**? ☐ Yes ☐ No ☐ ?

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ Yes ☐ No ☐ ?

If yes, what substances? _____

If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs, and/or supplements**? ☐ Yes ☐ No ☐ ?

If yes, please list them here and include information on how much and how often you use each one.

WOMEN ONLY:

Are you taking **birth control pills**? ☐ Yes ☐ No ☐ ?

Are you **pregnant**? ☐ Yes ☐ No ☐ ? If yes, number of weeks: _____

Are you **nursing**? ☐ Yes ☐ No ☐ ? If yes, number of weeks: _____

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:

Aspirin	☐ Yes	☐ No	☐ ?
Barbiturates, sedatives, or sleeping pills	☐ Yes	☐ No	☐ ?
Codeine or other narcotics	☐ Yes	☐ No	☐ ?
Hay fever/seasonal allergies	☐ Yes	☐ No	☐ ?
Iodine	☐ Yes	☐ No	☐ ?
Latex (rubber)	☐ Yes	☐ No	☐ ?
Local anesthetics	☐ Yes	☐ No	☐ ?
Metals	☐ Yes	☐ No	☐ ?
Penicillin or other antibiotics	☐ Yes	☐ No	☐ ?

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole), glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlothiazide (Microzide) and furosemide (Lasix) ☐ Yes ☐ No ☐ ?

Other ☐ Yes ☐ No ☐ ?

Please describe any "Yes" answers and include information about your experience. _____

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam:	What is your normal blood pressure (systolic, diastolic)? /

Doctor's Name: Phone:

Please use an "X" to mark your answers to the following questions.

Are you in good physical health? ☐ Yes ☐ No ☐ ?

Are you currently being seen or treated by a physician? ☐ Yes ☐ No ☐ ?

Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? ☐ Yes ☐ No ☐ ?

Have you had a **serious illness, operation, or been hospitalized** in the past 5 years? ☐ Yes ☐ No ☐ ?

Have you had any type (either total or partial) of **joint replacement** surgery (hip, knee, shoulder, elbow, finger, etc.)? ☐ Yes ☐ No ☐ ?

Have you had a **heart valve replacement or heart surgery**? ☐ Yes ☐ No ☐ ?

Have you had an **organ or bone marrow/stem cell transplant?** ☐ Yes ☐ No ☐ ?

Have you traveled internationally within the last 30 days? ☐ Yes ☐ No ☐ ?

Have you had a fever (100.4°F or above) in the last 72 hours? ☐ Yes ☐ No ☐ ?

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC

Do you have, or have you been diagnosed with, any of the following conditions?

Heart (Cardiac) Health

Pacemaker/implanted defibrillator	☐ Yes	☐ No	☐ ?
Artificial (prosthetic) heart valve	☐ Yes	☐ No	☐ ?
Previous infective endocarditis	☐ Yes	☐ No	☐ ?
Congenital heart disease (CHD)	☐ Yes	☐ No	☐ ?
Unrepaired, cyanotic CHD	☐ Yes	☐ No	☐ ?
Repaired (completely) in last 6 months	☐ Yes	☐ No	☐ ?
Repaired CHD with residual defects	☐ Yes	☐ No	☐ ?
Arteriosclerosis	☐ Yes	☐ No	☐ ?
Coronary artery disease	☐ Yes	☐ No	☐ ?
Congestive Heart Failure	☐ Yes	☐ No	☐ ?
Damaged heart valves	☐ Yes	☐ No	☐ ?
Heart attack	☐ Yes	☐ No	☐ ?
Heart murmur/rhythm disorder	☐ Yes	☐ No	☐ ?
Rheumatic heart disease	☐ Yes	☐ No	☐ ?
Stroke	☐ Yes	☐ No	☐ ?

Breathing (Respiratory) Health

Asthma (COPD)	☐ Yes	☐ No	☐ ?
Bronchitis	☐ Yes	☐ No	☐ ?
Emphysema	☐ Yes	☐ No	☐ ?
Sinus trouble	☐ Yes	☐ No	☐ ?
Tuberculosis	☐ Yes	☐ No	☐ ?
Cancer	☐ Yes	☐ No	☐ ?

Type: _____

Date of diagnosis: _____

Chemotherapy: _____

Radiation Treatment: _____

Blood (Circulatory) Health

Anemia	☐ Yes	☐ No	☐ ?

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MEDICAL HISTORY SPECIFIC CONTINUED

Blood (Circulatory) Health Continued

Blood transfusion..... ☐ Yes ☐ No ☐ ?
If yes, date:_____
Hemophilia..... ☐ Yes ☐ No ☐ ?
High or low blood pressure..... ☐ Yes ☐ No ☐ ?

Brain (Neurological)/Mental Health

Anxiety..... ☐ Yes ☐ No ☐ ?
Depression..... ☐ Yes ☐ No ☐ ?
Epilepsy..... ☐ Yes ☐ No ☐ ?
Mental health disorders..... ☐ Yes ☐ No ☐ ?
Neurological disorders..... ☐ Yes ☐ No ☐ ?
Post-traumatic stress disorder..... ☐ Yes ☐ No ☐ ?
Traumatic brain injury or concussion..... ☐ Yes ☐ No ☐ ?

Autoimmune Disease

AIDS or HIV infection..... ☐ Yes ☐ No ☐ ?
Lupus..... ☐ Yes ☐ No ☐ ?

Digestive Health

Gastrointestinal disease..... ☐ Yes ☐ No ☐ ?
G.E. reflux/persistent heartburn (GERD)..... ☐ Yes ☐ No ☐ ?

Digestive Health Continued

Stomach ulcers..... ☐ Yes ☐ No ☐ ?

Eye (Vision) Health

Glaucoma..... ☐ Yes ☐ No ☐ ?

Other

Arthritis..... ☐ Yes ☐ No ☐ ?
Chronic pain..... ☐ Yes ☐ No ☐ ?
Diabetes (type I or II)..... ☐ Yes ☐ No ☐ ?
Eating disorder..... ☐ Yes ☐ No ☐ ?
Frequent infections..... ☐ Yes ☐ No ☐ ?
Type of infection:_____
Hepatitis, Jaundice, or Liver Disease..... ☐ Yes ☐ No ☐ ?
Immune deficiency..... ☐ Yes ☐ No ☐ ?
Kidney problems..... ☐ Yes ☐ No ☐ ?
Malnutrition..... ☐ Yes ☐ No ☐ ?
Osteoporosis..... ☐ Yes ☐ No ☐ ?
Rheumatoid arthritis..... ☐ Yes ☐ No ☐ ?
Sexually transmitted infection (STI)..... ☐ Yes ☐ No ☐ ?
Thyroid problems..... ☐ Yes ☐ No ☐ ?

Do you have any disease, condition, or problem that's not listed here? If so, please explain:

MEDICAL SYMPTOMS/GENERAL

In the past 30 days, have you:

Had pain or tightness in the chest?..... ☐ Yes ☐ No ☐ ?
Coughed up blood or had a cough that lasted longer than 3 weeks?..... ☐ Yes ☐ No ☐ ?
Been exposed to anyone with Tuberculosis?..... ☐ Yes ☐ No ☐ ?
Had a rapid or irregular heartbeat?..... ☐ Yes ☐ No ☐ ?
Found it hard to catch your breath?..... ☐ Yes ☐ No ☐ ?
Had a high fever (greater than 101.5°F)?..... ☐ Yes ☐ No ☐ ?
Noticed a change in your vision?..... ☐ Yes ☐ No ☐ ?
Fainted for no reason?..... ☐ Yes ☐ No ☐ ?
Experienced vomiting, diarrhea, chills, night sweats, or bleeding?..... ☐ Yes ☐ No ☐ ?
Had migraines or severe headaches?..... ☐ Yes ☐ No ☐ ?

DENTAL INSURANCE

Insurance: Policy ID #:

Name of Policy Holder: DOB: Group #:

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately, and to the best of my ability.

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

_____ _____

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 : _____

Patient Signature : _____ Date : _____

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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