Providence Medical Group-Hood River Family Medicine
1304 Montello Ave.
Hood River, OR 97031
541-387-1300 | fax 541-387-1301

Appointment date _______________

Appointment time _______________

Welcome to the Providence Medical Group-Hood River Family Medicine. We welcome you as a patient and thank you for choosing us to participate in your health care.

For your first appointment, please arrive **15 minutes prior to your scheduled appointment to complete registration process.** Additionally, we ask that you bring all medications you are currently taking, including supplements and over-the-counter medications, in the original bottles, so that they charted correctly upon your initial visit. **Please request the last six months of chart notes from your current primary care physician and the last two years of specialty care including labs and X-rays**.

Please see the enclosed information regarding your first appointment.

We request that you refrain from wearing perfumes or colognes, as we see many patients who are susceptible to allergic reactions to scents.

Please bring the following to your appointment:

- Photo ID
- Medical insurance card
- Completed enclosed forms
- All current medications, in the original bottles

If you have any questions, please call us at 541-387-1300.

We look forward to seeing you soon.

Providers: Ralph Carter, M.D., Janet Sjoblom, M.D., Maria Czarnecki, M.D., Michael Harris, M.D.

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History form:
Please fill out your medical history as completely as possible.

Medications:
Please bring in all your current medications in the original bottles.

Record release form:
If you are transferring from another care provider, please request your records be transferred to your new doctor before to your appointment. You will find this form, Authorization for Release of Medical Records, in your packet.

If you need a copy of your lab results, you can sign a two-year release of records in your physician's office.

Cancellation policy:
We ask that you contact our office at least 24 hours before to your scheduled appointment if you need to cancel or reschedule. This allows appointments for other patients.

Before your appointments:
Please arrive 15 minutes before your appointment to allow time for registration. Remember to transfer your medical records from your previous provider.

Notice:
If you arrive more than 10 minutes past your scheduled appointment time, you may be asked to reschedule your appointment.

Billing Questions: 541-387-8219 or 877-215-7833

Medical History Form

MEDICATIONS (If none, so state)

DATE:

NAME:

HABITS (If none, so state)

DRUG REACTIONS (If none, so state)

Alcohol

Tobacco

Other

PAST MEDICAL HISTORY (Include 1. Hospitalizations; 2. Illnesses; 3. Operations; 4. Injuries; 5. Childhood and allergic illnesses; 6. Blood Transfusions. Indicate dates and hospitals. If any of the six categories are negative, so state)

OSTETRICAL/GYNECOLOGICAL HISTORY

Age first menses

Age of menopause (if applicable):

Number of pregnancies:

Number of live births:

Past sexually transmitted diseases

FAMILY HISTORY (Record age, state of health or cause of death)

Father

Mother

Brothers

Sisters

Children

Other

Familial disease

(Use pedigree sheet if appropriate)

SOCIAL HISTORY (include: 1. Education; 2. Marital history; 3. Employment history; 4. Interests, hobbies)

Others Involved in Your Health Care

This office requires a signed release to give any information regarding appointments, test results, health status, etc. to others. Anyone not listed on this form will not be given any information without a separate, specific release signed by the patient or legal representative.

Please note: Patients are no longer considered minors after age 17. If a patient over the age of 17 wishes to release information to a parent or guardian, they must include the name and relationship of that person on this form. Information will not automatically be given because a patient resides with his or her parent(s) or guardian(s).

Medical information is to be released to:

Name	Relationship	Phone number

Patient name [Print] ______________________ **Date of birth** ______________________

Authorized signature ______________________ **Today's date** ______________________

Legal representative if not patient [Print] ______________________ **Relationship** ______________________

MR# ______________________

Authorization for Release of Medical Records

Patient's Name: ______________________________
First *Middle* *Last*

Date of Birth: ___ / ___ / ___ **Social Security Number:** ______________

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

FROM:
Name (Medical Provider holding records): ______________________________
Address: ______________________________

TO:
Name: Janet Sjoblom, M.D., Ralph Carter, M.D., Maria Czarnecki, M.D., Michael Harris, M.D. **Phone #** (541) 387-6125
Address: 1304 Montello Ave, Hood River, OR 97031 **Fax #** (541) 387-1301

The purpose of the release is: ☐ Diagnostic Evaluation ☐ Reimbursement ☑ Follow-Up Care ☐ Legal ☐ Other

The following information may be released: ☑ Clinical notes (Re: ______________________)

☑ Laboratory Reports (LAST 2 YEARS) ☑ Immunization Records ☑ Medication Records ☑ X-Ray Reports

☑ Other: EKG'S, PATHOLOGY REPORTS, SPECIAL STUDIES, SPECIALISTS' CONSULTS, HOSPITAL RECORDS INCLUDING ER VISITS, ADMITS, H&P'S, IN PT. CONSULTS, SURGERY/PROCEDURE REPORTS, AND DISCHARGE SUMMARIES (LAST six MONTHS ONLY)

Information may be released for dates of service from SEE ABOVE through SEE ABOVE

This authorization expires six months from the date signed or: ______________________ (specified expiration date)

I have read the above and fully understand its contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

______________________________ (Signature of patient or representative)

______________________________ Relationship (if signed by representative)

______________________________ Date Signed

______________________________ Witness (optional)

Driver's License/Identification ______________________________

I do ____/do not ____ specifically consent to transmission of my medical records via a facsimile (fax) machine. Signature Date	I recognize that the information disclosed may contain drug/alcohol information that is protected by Federal and State law. I specifically consent to disclosure of such information Signature Date
I recognize that the information disclosed may contain mental health information that is protected by Federal and State Law. I specifically consent to disclosure of such information Signature Date	I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV / AIDS testing information. I specifically consent to disclosure of such information Signature Date

This authorization may be revoked at any time unless prior action has been taken as a result of this form. Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulations (Title 42 of the Federal Register) which prohibits re-disclosure.

Medical Record # ______________

Providence
Prescription Refill Policy

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Please request **all** prescription refills through your pharmacy:

- Your pharmacy's phone number and your prescription number should be on your prescription bottle.
- Call your pharmacy even if you have no refills remaining. Your pharmacy will contact your doctor for authorization.
- If you are changing pharmacies, your new pharmacy can contact your previous pharmacy and transfer your existing prescriptions. Your new pharmacy will contact our office if refills are needed.

Call your doctor's office for a refill **only** if:

- Your prescription needs to be picked up in person.
- You have a question about your medication.

Please allow at least 72 hours to approve your refill request, as our refills are processed by a central refill service in Portland.