



Patient Name _____ Date ____/____/____

Tri-State Family Practice

Which clinic location do you prefer to be seen in? Clarkston Lewiston Clearwater Any

Please check below if there is a specific provider you would like to see.

Tri-State Family Practice Clarkston	Tri-State Family Practice Lewiston	Tri-State Family Practice Clearwater
<input type="checkbox"/> Tyler Anderson, PA-C <input type="checkbox"/> Heather Davis-Remacle, PA-C <input type="checkbox"/> Luke Megna, MD, FAAFP <input type="checkbox"/> John Merrill, DO <input type="checkbox"/> Jeremy Ostermiller, PA-C <input type="checkbox"/> Carson Seeber, MD	<input type="checkbox"/> Jennifer Creaser, ARNP <input type="checkbox"/> Mary Crowell, DO <input type="checkbox"/> John Rudolph, DO <input type="checkbox"/> Alexa Rhea, PA-C	<input type="checkbox"/> Celso Chavez, MD <input type="checkbox"/> Cody Harris, DNP <input type="checkbox"/> Robin Hight, NP-C <input type="checkbox"/> Cheryl Loetscher, NP-C <input type="checkbox"/> Christine Norwood, NP-C <input type="checkbox"/> Jessi Six, FNP-BC <input type="checkbox"/> Theresa Smith, NP-C <input type="checkbox"/> Sherry Sweikert-Smith, DNP <input type="checkbox"/> Doris Ziegeldorf, FNP-BC

Patient Information (as it appears on insurance card)

Patient Name _____ Date of Birth ____/____/____ Male _____ Female _____
 Mailing Address _____ City _____ State _____ Zip _____
 Phone # _____ Phone Type _____ Alt Phone # _____ Phone Type _____
 Email _____ Social Security # _____
 Other Last Name(s) Used _____ Preferred Language _____
 Race African American Alaska Native American Indian Caucasian Hispanic or Latino Native American Other _____
 Guarantor (Full Name) _____ Guarantor Date of Birth ____/____/____

Emergency Contact Information

Name _____ Phone # _____ Phone Type _____
 Relationship to Patient _____

Insurance Information

Primary Insurance _____ Subscriber Name _____
 Policy/ID # _____ Group # _____ Phone # _____ Phone Type _____
 Secondary Insurance _____ Subscriber Name _____ Date of Birth ____/____/____
 Policy/ID # _____ Group # _____ Phone # _____ Phone Type _____

Employer Information

Employer Name _____ Phone # _____ Phone Type _____
 Address _____ City _____ State _____ Zip _____ Full-time Part-time

Reason for Visit/Establishing Care - Current/Past Medical Problems

Accident Related? Yes No Previous Primary Care Provider _____ Date Last Seen _____
 How often do you go to the doctor in a year? _____ Do you have any family members that see one of our providers? Yes No
 Who recommended you to our clinic or how did you hear about us? _____

Allergies - Please list any allergy or intolerance you have to medications or environment (i.e. dust, nuts, animals)

Medication or Environmental Issue	Reaction

Current Medications - Include all prescription and non-prescription (over-the-counter) medications

Medication Name	Dose (mg, mcg, %)	How Often?

If you are not currently taking any medications (prescription or over-the-counter), check here



Patient Name _____ Date ____/____/____

Past Medical History

Have you had a colonoscopy? Yes No If yes, when? _____ Providers Name _____

Women: Age when menses began _____ If post-menopausal, when was your last period? _____

At what age did you have your first child? _____ Total number of pregnancies _____ Miscarriages? _____

Have you had any of the following? (list type if requested)	Yes	No	Date Issue Began
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Acid Reflux			
Anemia			
Anxiety			
Arthritis			
Asthma			
Bleeding Tendency			
Blood Clots			
Blood Disorder - Type?			
Bowel Disease - Type?			
Cancer - Type?			
Chronic Muscle Pain			
Daytime Sleepiness			
Depression			
Diabetes - Type?			
Gallbladder Problems			
Gout			
Heart Trouble			
Hepatitis - Type?			
Hereditary Defect - Type?			
High Blood Pressure			
High Cholesterol			
Insomnia			
Joint Pain			
Kidney Failure			
Kidney Stones			
Liver Disease			
Lung Problems - Type?			
Migraines			
Osteoporosis			
Pancreatitis			
Rheumatic Fever			
Seizures			
Sexually Transmitted Disease - Type?			
Stomach Ulcers			
Stroke			
Substance Abuse Disorder - Type?			
Thyroid Gland Trouble			
Tuberculosis (TB) - Exposure or Contracted?			
Ulcers - Type?			

Other - Please Describe: _____



Patient Name _____ Date ____/____/____

Additional Medical Issues	Year Issue Began

Past Surgeries - List Type of Surgery	Year

Immunization History - Do not fill out unless you have specific dates	Month/Day/Year
Pneumovax (Pneumonia Vaccine)	
Zostavax (Shingles Vaccine)	
Tetanus	
PPD (Tuberculin Skin Test)	
Hepatitis A	
Hepatitis B	
Meningococcal	
MMR (Measles, Mumps, Rubella Vaccine)	
Varicella (Chickenpox Vaccine)	
Other - Please List:	

Family History - List which relative (i.e. mother, father, brother, sister, aunt, uncle, maternal/paternal grandparent, etc.)		
Illness	Family Members (please list)	If grandparent, maternal or paternal?
Arthritis		
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		
Heart Attack		
Migraines		
Seizures		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		



Patient Name _____ Date ____/____/____

Social History

Marital Status (please choose) Single Married Separated Divorced Widowed
 Do you smoke? Yes No Frequency? _____ Did you smoke in the past? Yes No
 How many years did you smoke? _____ When did you quit smoking? _____
 Do you use smokeless tobacco? Yes No Frequency? _____ Did you use smokeless tobacco in the past? Yes No
 How many years did you use smokeless tobacco? _____ When did you quit using smokeless tobacco? _____
 Do you drink alcohol? Yes No How much/frequency? _____
 Do you smoke marijuana? Yes No How much/frequency? _____
 Do you use recreational drugs? Yes No Type _____ How much/frequency? _____

My Health Portal

My Health Portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. Using a secure username and password, patients can view health information such as, recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results, upcoming radiology appointments, and more.

Have you signed up for My Health Portal? Yes No If no, please check here if you would like to sign-up

Pharmacy Preference

Pharmacy Name _____
 Pharmacy Address _____ City _____ State _____ Zip _____
 Pharmacy Phone # _____ Pharmacy Fax # _____

Additional Comments: _____

Please complete this form and send to:

MAIL: Tri-State Memorial Hospital
 ATTN: New Patient Coordinator
 1221 Highland Avenue
 Clarkston, WA 99403

FAX: 509.769.2015

EMAIL: newpatients@tsmh.org

Questions? Please contact the New Patient Coordinator at 509.769.2014 or newpatients@tsmh.org