White Oak Medical Clinic
Diane Bolduc, MD | Marie Hebert, MD
Emma Hebert FNP | Rachel Hebert FNP
340 Medical Loop Roseburg, OR 97471
Tel 541-464-5907 | fax 541-464-8481

Patient History

Name:	**Date of Birth:**	**Sex:** M__F__	**Today's Date:**

Occupation:	**Marital Status:**	**Birthplace:**

Special Interests:

Medications	3.
1.	4.
2.	5.

Allergies:
Penicillin__ Sulfa__ Aspirin__ Foods__
Pollen__ Other__

Vaccinations- Specify year received
Tetanus _____ Shingles_____ Pneumonia_____
Hep A _____ Hep B_____ Other

Illnesses	**Check if you or your family have had these:** Self	Father	Mother	Sibling
Alcoholism				
Arthritis				
Asthma				
Cancer				
Diabetes				
Diverticulitis				
Eczema				
Heart Attack/ Heart Disease				
Hepatitis				
High Blood Pressure				
Irritable Bowel (IBS)				
Kidney Disease				
Mental Health Disorder				
Seizures				
Sexually Transmitted (STD)				
Stroke				
Other				

Surgical Operations	**Year**
Tonsillectomy	
Appendectomy	
Hysterectomy	
Ovarian	
Gall Bladder	
Other	

Preventative Care	**Month/Year**
Colonoscopy	
Mammogram	
Pap smear/ prostate exam	
Cholesterol check	
Other	

Female Only		
Number of pregnancies:		
Number of children:		
Birth control method:		
Breast concerns	Yes	No
Pelvic pain	Yes	No
Irregular Periods	Yes	No

Date of last period: _____ Heavy___ Moderate___ Light___

Risk Factors			
Do you or did you ever smoke or chew tobacco? Yes No	How much?	Start date?	Quit Date?
Do you consume alcohol? Yes No	How much?	How often?	Quit Date?

Male Only		
Difficulty urinating	Yes	No
Prostate/ Testicular concerns	Yes	No
Erectile/Ejaculation concerns	Yes	No

Systems review
Have you recently experienced any of the following or are any of concerns to you?

Weight change	Yes	No	Diarrhea	Yes	No
Fatigue	Yes	No	Constipation	Yes	No
Headache/ Migraines	Yes	No	Heartburn/ acid reflux	Yes	No
Tremors	Yes	No	Blood in your stool	Yes	No
Incontinence of urine or bowel	Yes	No	Blood in your urine	Yes	No
Cough	Yes	No	Excessive thirst and/or urination	Yes	No
Difficulty breathing	Yes	No	Depression/ Anxiety	Yes	No
Nasal congestion	Yes	No	Change in sleep pattern	Yes	No
Itchy eyes/ears	Yes	No	Muscle weakness	Yes	No
Chest pain or tightness with exertion	Yes	No	Pain in your joints	Yes	No
Ankle swelling	Yes	No	Skin rash	Yes	No
Palpitations	Yes	No	Suspicious skin lesions	Yes	No

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Fax (541) 464-8481

May we leave messages on your answering machine? Yes No

May we contact you at work? Yes No

Please provide names below of all people we may speak with or leave a message with regarding the patient's medical care, appointment scheduling, or billing information.

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Emergency Contact – Name: Phone:

Address: Relationship:

Print (**Patient** Name): _____

DOB: _____ Phone Number: _____

Signature: _____ Date: _____
(**Patient**/Guardian)

White Oak Medical Clinic

340 Medical Loop
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Phone: (541) 464-5907

Patient Information

Patient's Full Name: _____ Date of Birth: _____

Address: _____ City, State: _____ Zip: _____

Best phone to reach you: 1.) _____ 2.) _____

Preferred Language: _____

White Oak Medical Clinic is proudly recognized as a Tier 3, Patient-Centered Primary Care Home (PCPCH). A PCPCH is a health clinic that is recognized for their commitment to patient-centered care. Primary care homes are accessible, accountable, comprehensive, continuous, coordinated and patient and family centered. Our goal is to provide you with the best care possible.

Office Hours

Monday, Thursday and Friday	**8 am – 5 pm with a lunch from 12:00 pm - 1 pm**
Tuesday and Wednesday	**8 am – 6 pm with a lunch from 12:00 pm – 1 pm**
Saturday	**8 am – 2 pm except for the first Saturday of the month; we are closed.**

If you reach our office outside of these hours, please leave a message and we will return your call on the next business day.

***********Please contact your pharmacy directly for all prescription refills**********

Electronic Medical Records & Photograph Notice:

This office participates in the DCIPA Community Health Record Database. This means we enter your health information, including your chart notes, prescription records, operation notes, radiographs and scans, labs and other health related information in a secure shared database accessible only to other participating community healthcare providers. Unless you have instructed otherwise, your medical providers participating in the database do the same thing, permitting all your participating providers including this office, instantaneous access to the most up to date information regarding your condition and care. By signing below you authorize us to upload your health information onto the database, to view all your personal health information on the database and to share this information with the other database participating providers. If there is any information you do not want entered in the database please talk directly with your provider. You understand and agree to have your photograph taken, updated, kept and used in the DCIPA Community Health Record Database for identification, fraud prevention and to assist with your medical care.

Payment Information:

Copayments, deductibles, past balances and private pay payments are due before time of service. We accept cash, checks, and credit cards. Balances are due within 30 days. Accounts 90 days past due are subject to collection procedures.

"I have read, understand and agree to the above payment policy. I also understand and agree that I am ultimately responsible for the balance of my account for any professional service rendered. I certify that the information I provided on this form is true to the best of my knowledge and will notify this office of any change in this information. I also acknowledge that I have received a copy of this office's notice of privacy practices, which states how it may use and/or disclose my health information." * You may refuse to sign the acknowledgement if you wish by crossing out this paragraph.

Signature: _____ Date: _____

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This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please Review it carefully.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This Notice will take effect on 01/03/2005 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our privacy notice at any time by contacting our privacy officer. Information contacting us can be found at the end of this notice.

Typical uses and Disclosures of health information:

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their job functions. Everyone in our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Healthcare information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or supplies unless you have advised otherwise.

Emergencies: We may use or disclose your healthcare information to notify, or assist in the notification of a Family member or anyone responsible for your care, in case if an emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make responsible inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your healthcare information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required By Law: We may use and disclose you healthcare information when we are required to by law. (court or administrative orders, subpoena, discovery request or lawful process.) We will use and disclose your information when requested by national security, intelligence, and or state and federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your healthcare information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The Health Information of Armed Forces personal may be disclosed to military authorities under cretin circumstances. If the information is required for lawful intelligence, counterintelligence or other national Security activities, we may disclose to authorized federal officials.

Appointment Reminders: We may use or disclose you healthcare information to provide you with appointment reminders. Including but not limited to, Voicemail messages, Postcards or letters.

Your Privacy rights as our patient

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you Legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit the appropriate request form. Contact our privacy officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this notice. Once approved, an appointment can be made to review your records. Copies if requested will be a $25.00 fee for 10 or fewer pages and a .25cent for each additional page. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or a brief explanation of your health information, we will provide it for a fee. Please contact our privacy office for a fee and/or an explanation of our fee structure. Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request may be in writing and must include an explanation of why the information should be amended. Under cretin circumstances your request may be denied. Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your healthcare information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, our business associates, disclosed information other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14th, 2003. Information prior to that date would not have to be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our privacy officer is you want to further restrict access to your healthcare information. This request must be submitted in writing.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our privacy policies. Your complaint should be directed to our Privacy officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a complaint form for our privacy officer. We support our right to the privacy of your information and will not relate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human services.