MENDY MACCABEE, MD
514 State Street • Hood River, OR 97031 • 541 - 436 - 3880 • Fax 541-436-3881

PATIENT INFORMATION

Social Security #: _____ Email: _____

Last: _____ First: _____ Middle Initial: _____
Suffix (Jr., etc)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female Ht: _____ Wt: _____

Primary Care Provider: _____ Referring Provider: _____

Emergency Contact and Phone: _____ (___) _____
Different than above

RESPONSIBLE PARTY INFORMATION

(IF PATIENT IS A MINOR OR IF POWER OF ATTORNEY IS INVOLVED)

Last: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female

Social Security Number: _____ Relationship to Patient: _____

Employer Name: _____ Employer Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Patient or Responsible Party Signature _____ Date: _____

The Patient Portal enables patients and doctors to communicate with one another over the Internet. Using a secure password, patients can access their own personal information including labs, diagnostics, statements and messages. We encourage all patients to enroll for the Patient Portal.

Please check to enable access ☐

MENDY MACCABEE, MD • HOOD RIVER, OR

MEDICAL INSURANCE

Patient Name: _____

PRIMARY

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Copayment amount: _____ (Copayments are due at time of visit)

SECONDARY

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Is this appointment due to an on-the-job accident? ☐ YES ☐ NO Date of injury: _____
If yes, an 827 form will need to be filled out at your first visit.

Is this appointment due to a motor vehicle accident? ☐ YES ☐ NO Date of injury: _____
If yes, an MVA form will need to be filled out at your first visit.

AGREEMENT AND CONSENT

My signature acknowledges having read the following regarding my services

- I authorize the release of my personal health information according to the Notice of Privacy Practices
- I assign my insurance company benefit payments for services received.
- To provide correct personal information prior to service or be financially responsible for insurance benefit denial.
- To pay for services received that my insurance company considers a non-covered benefit.
- To pay for services deemed by my insurance company as medically unnecessary.
- Insurance Co-payments due at time of service. Appointments will be rescheduled until Co-payment can be made at the time of service. I agree to pay $50 if 'No Show' for appointment.
- I will pay insurance Deductibles determined by my insurance company as patient responsibility or make payment plan arrangements prior to receiving services.
- To pay for forms, letters or paperwork requests prior to receiving requested documents.
- Repeated no-show or cancellations may result in no future appointments.

_____

Print Name Signature Date

MENDY MACCABEE, MD • PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ Todays Date: _____

Reason for visit? _____ Height: _____ Weight: _____

If in pain, where exactly is your worst pain located? _____

How long have you had pain? _____ On a scale from 0 - 10, rate your pain: _____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

DAILY BLOOD THINNERS
(INCLUDING ASPIRIN): _____

WHAT DO YOU
TAKE FOR PAIN? _____

ALLERGIES:

_____

_____

_____

_____

LIST ALL PREVIOUS SURGERIES & DATES:

_____

_____

_____

PLEASE CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU:

☐ Diabetes	☐ Asthma	☐ Recurrent Falls	☐ Kidney Disease
☐ High Blood Pressure Heart	☐ COPD	☐ Headaches	☐ Liver Disease
☐ Disease	☐ Hypothyroid Disease	☐ Neuropathy	☐ Skin Conditions
☐ Heart Attack	☐ Gout	☐ Multiple Sclerosis	☐ Stomach Ulcers/Acid Reflux
☐ Stroke	☐ Muscle Weakness: Cause	☐ Rheumatoid Arthritis	☐ Raynaud's
☐ Peripheral Vascular Disease	☐ Arthritis	☐ Lupus	☐ Anxiety/Depression
☐ Blood Clots	☐ Claustrophobia	☐ Parkinson's Disease	☐ Cancer (Specify Type): _____
☐ High Cholesterol	☐ Fibromyalgia	☐ Hepatitis	☐ Other: _____

PLEASE INDICATE ALL FAMILY HEALTH HISTORY(PLEASE CIRCLE):

Heart Disease	Kidney Disease	Epilepsy
Headaches	Thyroid	Respiratory Disease
Kidney Disease	Diabetes	Cancer (Specify Type): _____

Other: _____

Mothers Current Health Condition: _____ Age:_____	Fathers Current Health Condition: _____ Age:_____

Please circle one:
Married Single Divorced Widowed

Job Title: _____ Hobbies/Recreactions: _____

Do you drink alcohol? ☐ YES ☐ NO How much per day? _____ Per week? _____

Do you smoke? ☐ YES ☐ NO How many per day? _____ How many years? _____

Do you exercise? ☐ YES ☐ NO How many times per week? _____ How long per workout? _____