**OAK STREET MEDICAL, P.C.**

Kraig W. Jacobson, M.D. 1488 Oak Street

Sarah S. Kehl, M.D. Eugene Oregon 97401

Jason Friesen, M.D. Ph: (541) 683-1577

Melanie Chala Wayne, F.N.P. Fax: (541) 344-6176

**Thank you for allowing us to become partners in your Health Care!**

**Enclosed you will find paperwork we need you to complete and bring with you for your appointment. If this is not completed when you come in it may delay your appointment time. Please arrive 15 minutes prior to your appointment time as additional paperwork will be needed at check in as part of the new patient registration process.**

**§** If your insurance is a managed care plan, a referral is required from your primary care physician in order to be seen by a specialist. With a managed care plan, please call to make sure the referral has been requested from your primary physician and received by the specialist.

**§** As a courtesy, our office will contact your insurance company to verify coverage and benefits. Please call us if you have questions about the amount you will need to be prepared to pay at your first appointment. Co-payments, Co-insurance and Deductible amounts are payable at the time of service. We accept cash, checks made payable to Oak Street Medical, Visa, MasterCard and Discover.

**§ Late Appointments:** The office may need to reschedule your appointment if you are late.

***Appointment Policy***

Our office requires 24 hour notice if an appointment cannot be kept. If you are unable to make your scheduled appointment, please notify us as soon as possible. You can call our main office number between 8am and 5pm. If before 8am or after 5pm, please leave a message on our voice mail. All “No Show” appointments are tracked within the patient’s medical record. There is a $50.00 fee attached to all “No Show” appointments subsequent to the first offense. With any additional “No Show” appointments following the second notice, our office will be unable to schedule any appointments in advance. Patients may call our office on the day he/she is available to attend an appointment to inquire if there is an opening that would work for them. Continued missed appointments will subject the patient’s account for review of possible termination from the Practice.

If you have any questions, please feel free to call the office during regular business hours.

We look forward to meeting you soon.

Warmest regards,

The Office Staff

Oak Street Medical

NEW PATIENT HISTORY FORM

Patient Name: DOB:

**Please list ALL Medications you are currently taking, including over the counter and skin creams/ointments: (Please bring your medicines to your appointment)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any medication ALLERGIES and reaction to those medications (include LATEX):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of work do you do?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have mold/mildew or water leaks in your home?  Yes  No

Do you use a fireplace, wood or pellet stove?  Yes  No

Do you have an air conditioner?  Yes  No

Do you have pets?  Yes  No

What kind?  Dogs  Cats  Other

Do they come inside?  Yes  No

Are you a current smoker?  Yes  No  Tobacco  Cannabis

Have you smoked in the past?  Yes  No

Is there smoking at home (indoor or outdoor)?  Yes  No

If you smoke or have smoked:

Number of packs per day: \_\_\_\_\_\_\_\_ Number of years \_\_\_\_\_\_\_\_

Page 1

NEW PATIENT HISTORY FORM

Patient Name:  DOB:

**Please check all that are appropriate:**

REVIEW OF SYSTEMS

Systemic:  feeling tired/fatigued  fevers or chills  other

Cardiovascular:  high or low blood pressure  irregular heart rhythm

 swollen ankles (edema)  heart failure

 Chest pain/angina/heart attack  other

Gastrointestinal:  abdominal pain  heartburn

 vomiting  diarrhea  other

GU:  difficulty urinating  pain with urination  other

Endocrine:  diabetes/high blood sugars  thyroid problems  other

Hematologic:  anemia  swollen lymph nodes  other

Musculoskeletal:  muscle aches/pains  swollen joints  other

Neurological:  headaches  dizziness  other

Psychological:  depression  anxiety  other

Skin:  itching  rash  other

FAMILY HISTORY

Is there a history of any of the following in your immediate family (parents or siblings)?

Environmental allergies  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurrent infections  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hives  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2