



New Patient Welcome Packet  
Pediatric 6-17 years



Greetings,

Welcome to Orchid Health! Our Health Clinics were founded on the belief that our state's rural communities deserve to have extremely high quality healthcare that is local, comprehensive, and takes the time to address what matters most to each individual.

We have brought together the following care team members to provide individualized, comprehensive care:

Primary Care Provider (PCP): Your PCP will help you think through important health decisions and may connect you with another member of the care team to make sure that you are getting the best care.

Medical Assistant (MA): Your Medical Assistant will often be the first person you talk with when you have a health concern and will work closely with your PCP to help support any standard ongoing healthcare needs.

Nurse Care Coordinator (RN): At Orchid, we have nurses that help you design a personalized Care Plan, including identifying your personal health goals and planning for any upcoming preventive health items.

Behavioral Health Provider (BH): Our Behavioral Health Providers are available to help with any mental, emotional, or behavioral health needs that you may have. This may include making lifestyle changes, dealing with sadness or loneliness, or problems at home or school.

Enclosed are our new patient registration forms. Please complete these forms to the best of your knowledge. Included is a *Medical Records Release Form*, which allows us to request your past medical records prior to your first visit. We ask that you complete this form and drop it off at our clinic as soon as possible. Additionally, a *Controlled Substance Agreement* must be signed before the prescription of controlled substances by Orchid Health providers.

In order for us to best serve you:

1. Please check in at the clinic 15 minutes prior to your scheduled appointment time.
2. Please bring your insurance card and your ID with you to your visit.
3. Please bring the bottles of any current medications you are taking.
4. If you need to cancel or reschedule your visit please provide us with 24 hours notice.

Oakridge: Clinic Phone # 541-782-8304

- We are located on Highway 58, right near the Pharmacy.
- Our hours of operation are: Monday, Tuesday, and Wednesday from 8am to 7pm and Thursday and Friday from 8am to 5pm. For after hours support, call our main clinic phone #.

Estacada: Clinic Phone # 503-630-8550

- We are located on the High School Campus, just to the right of the Estacada High School.
- Our hours of operation are: Monday and Tuesday from 8am to 7pm and Wednesday, Thursday, and Friday from 8am to 5pm. For after hours support, call our main clinic phone #.

McKenzie River: Clinic Phone # 541-822-3341

- We are located at 51730 Dexter St., Blue River just off of the McKenzie River Hwy
- Our hours of operation are: Monday through Thursday from 8am to 5pm. For after hours support, call our main clinic phone #.

## **FAQ - Frequently Asked Questions!**

### **How do I make an appointment?**

- Most people call our office to schedule an appointment.
- You can also request an appointment through our Patient Portal.

### **What is the Patient Portal?**

- The Portal allows you to send messages directly to your Provider, instead of calling. It also allows you to see any lab and imaging results as soon as we receive them.
- You can find the portal link on our website: [www.orchidhealth.org](http://www.orchidhealth.org) (upper right corner). - Ask any of our staff for help. We can send you an email link or set you up when you come in.

### **What days and hours are you open?**

- *Oakridge*: Monday, Tuesday, and Wednesday 8-7, Thursday and Friday 8-5
- *Estacada*: Monday and Tuesday from 8-7, Wednesday, Thursday, and Friday from 8-5
- *McKenzie River*: Monday - Thursday from 8:30 am - 5:00 pm, closed on Fridays.

### **What if I need to reach someone after the office is closed?**

- Easy! Use the same phone number you normally call and listen for the option to reach our After-Hours Nurse Service.

### **How do I get my Prescription Refilled?**

- The best FIRST step is to call your pharmacy and ask them for a refill - they will then contact us directly if needed.
- If you are having any difficulty, please call us so we can resolve it for you. (Or use the Patient Portal!)
- Any "controlled medication RX" needs to be given during an appointment. (This would include things like pain medication, certain anxiety or sleep medication, etc).

### **Can I have my blood tests drawn at Orchid?**

- Yes, we draw labs for the patients who have *established* with us (even if ordered by others).

### **Do you do X-RAYS at Orchid?**

- No, sorry, at this time, we do not have an X-RAY machine at any of our sites - but we can give you an order to do your test somewhere else.

### **How can I get my lab or X-RAY/imaging results?**

- If you have a follow-up appointment scheduled, then your provider is probably planning to review your lab results at that time, but we will call you with anything really important so nothing gets overlooked.

### **What if I am worried about paying for my visit or labs?**

- We don't want money to stand in the way of your health care, so please talk to us about your concerns.
- Ask about our Sliding Fee Discount, too!

**Do you see Kids? What about Babies? What about Seniors?**

- Yes, Yes, and Yes!

**ORCHID HEALTH REGISTRATION FORM - MINOR**

(Please print)

Patient's Legal Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

*First - Middle - Last*

Preferred name/name that you go by: \_\_\_\_\_

Legal Sex: Male/Female/Other Date of Birth (mm/dd/yy): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Parent/legal guardian #1 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Lives with child:  Yes  NoParent/legal guardian #2 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Lives with child:  Yes  No

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Consent to text?  Yes  No

Email: \_\_\_\_\_ Preferred communication method: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Race: (You can choose more than one if appropriate)  White  Black or African American  Asian American Indian or Alaska Native  Native Hawaiian or other Pacific Islander  Hispanic or Latino OriginEthnicity:  Not Hispanic/Latino  Hispanic/Latino  Other \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**INSURANCE INFORMATION**

(please bring your insurance card to our receptionist)

**Please indicate primary insurance name:** \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of SUBSCRIBER: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other**Name of secondary insurance (if applicable):** \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of SUBSCRIBER: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other**PERSON Financially Responsible for Bills and Payment:**

Relationship to patient: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Best Phone Number: \_\_\_\_\_

**CONSENT FORM - MINOR**

Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age except for family planning, sexually transmitted disease services, and certain mental health services. ORS 109.610, ORS 109.640, ORS 109.675.

I understand the following types of services are offered through Orchid Health:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Management of Chronic Health Conditions
- Age appropriate reproductive health
- Routine lab tests, Immunizations
- Prescription medications
- Mental health services
- Referral for health care services not provided by Orchid Health

I have read and fully understand the above information, have asked questions about anything not clear to me. I understand that I may revoke this consent at any time.

I (parent/legal guardian) \_\_\_\_\_ give permission for my child,  
\_\_\_\_\_, to receive medical care at Orchid Health.

**Authorization of Payment:**

Parent or Guardian: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and also authorize the release of any medical records necessary to facilitate my treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. I fully understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

**Notice of Privacy Practices:** I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice can be found on our website under patient forms, is available at the clinic upon check-in, and is otherwise available to me at any time upon request.

**Patient Rights and Responsibilities:** I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities. These can be found on our website under patient forms, is available at the clinic upon check-in, and is otherwise available to me at any time upon request.

**Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to local Hospital Networks to Access Health History Information:** I authorize the release of my historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

**Consent to Call:** I consent to receive calls from Orchid Health for my protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**AUTHORIZATION TO DISCLOSE INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Authorization to Disclose Information to Others:**

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

**I give permission to release the following information to the individuals listed below:**

- All health information about me created or received by Orchid Health, including medical records, case or medical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.
- All health information **except for:** mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

**Permission for non-guardian to consent for child's medical treatment (if patient is under 15 y/o):**

- I give permission for the above listed individual(s) to provide consent for treatment on my behalf and to accompany my child to their medical appointments.

**Personal Communication Methods:**

As our patient, we may need to communicate with you outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

Home Phone # \_\_\_\_\_

- Do NOT leave messages
- May leave call back numbers only
- May leave messages with details

Mobile Phone # \_\_\_\_\_

- Do NOT leave messages
- May leave call back numbers only
- May leave messages with details

**TERM:** This authorization will remain in effect for a period of **one year**. I can revoke this authorization in writing (at any time) as described in the Orchid Health Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**MEDICAL RECORDS RELEASE**

Patient Name \_\_\_\_\_ Former Name (if any) \_\_\_\_\_

Current Address \_\_\_\_\_ D.O.B. \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip \_\_\_\_\_ S.S.# \_\_\_\_\_

Best Contact Phone \_\_\_\_\_

**I Authorize Information Released FROM:** (please print)

Clinic/Doctor's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

**Please Send My Records TO:** (fax preferred circle one)

Orchid Health	Orchid Health	Orchid Health
<i>Wade Creek</i>	<i>Oakridge</i>	<i>McKenzie River Clinic</i>
534 NE 6TH Ave. Estacada , OR 97023 Fax: (503) 630-8551 Ph: (503) 630-8550	47815 Highway 58 Oakridge, OR 97463 Fax: (541)782-5823 Ph. (541) 782-8304	51730 Dexter St. Blue River, OR 97413 Fax: 1 (833) 905-2303 Ph. (541) 822-3341

**Purpose of Release**

- Establishing New PCP
- Sharing Health Information (from Consultant/Specialist)
- Personal Use
- Legal

**Type of Information To Be Released-** Initial **ALL** that apply

\_\_\_ **Complete** Medical Records \_\_\_ Include Mental Health Records \_\_\_ Include Confidential Records/HIV or other  
\_\_\_ Include Records relating to Drug or Alcohol Treatment: \_\_\_\_\_  
\_\_\_ Other (specify): \_\_\_\_\_

**This authorization will expire one year from the date of the signature below.**

I understand that I can change my mind about this authorization at any time by writing to the health care provider or to Orchid Health, but that any information already transferred will remain in our Confidential Medical Record System.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information if it is relevant for consultation, or if you request we transfer your records to another location.
- I am allowed to receive a copy of this Authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



**New Patient Health History - Pediatric 6-17 years**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Current Medical Concerns** (what you would like to talk about today):

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

**Please list any allergies you have to medications:**

NAME OF MED                                  Reaction

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

**Please list any medications you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:**

NAME OF MED                                  Dose                                  Directions (How often given)

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

**Immunizations**

Do you follow the recommended CDC vaccination schedule? No  Yes

Please explain if altering schedule: \_\_\_\_\_

**Any hospitalizations?** No  Yes  If yes, please explain below:

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

**Please circle any surgeries:**  Heart     Ear Tubes     Tonsils/Adenoids     Appendix     Circumcision

Frenulectomy (tongue clipping)     Eye Surgery     Hernia Repair, type: \_\_\_\_\_     Other: \_\_\_\_\_

**\*For ages 12-17 only\*** Who is filling out this portion of the form? \_\_\_\_\_

Sexually Active? No  Yes  If Yes, number of total partners (past and present): \_\_\_\_\_

If YES, do you use condoms always? No  Yes

Do you use another form of Birth Control or Contraception? No  Yes

Menstrual Periods started at age \_\_\_\_\_ Date of Last Menstrual Period \_\_\_\_\_

Any past pregnancies? No  Yes



## PERSONAL HEALTH HISTORY

ADHD or ADD	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Endometriosis	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Alcoholism/Substance Abuse	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Fibromyalgia	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Allergies/Hay fever	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Gout	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anemia	No <input type="checkbox"/>	Yes <input type="checkbox"/>	GYN Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anesthesia Complications	No <input type="checkbox"/>	Yes <input type="checkbox"/>	HIV	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anxiety Disorder or Recurrent Anxiety	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Heart Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Arthritis	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Hepatitis C	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	High Blood Pressure/Hypertension	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Autism Spectrum Disorder	No <input type="checkbox"/>	Yes <input type="checkbox"/>	High Cholesterol	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Bipolar or Schizophrenia	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Kidney Stones	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Birth Defects or Inherited Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Kidney or Bladder Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Blood Transfusion	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Liver Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cancer	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Migraines	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Chicken Pox	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Muscle, Joint, or Bone Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Clotting Problems/bleed too much	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Osteoporosis	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Depression	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Reflux/GERD	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Developmental or Behavioral Disorders	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Seizures/Epilepsy	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Diabetes or Pre-Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Skin problems (Rashes/Changing Moles)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Diverticulitis/Diverticulosis	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Stomach Ulcers or Swallowing Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Domestic Violence	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Stroke or TIA	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Ear Infections - Chronic	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Thyroid Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Ear or Hearing Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Tuberculosis or Positive TB Test	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Eating Disorder like Anorexia or Bulimia	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Vision or Eye Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Eczema	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Emphysema/COPD/Chronic Bronchitis	No <input type="checkbox"/>	Yes <input type="checkbox"/>			

## SOCIAL HEALTH HISTORY

Please answer the following questions to help us better understand how we may best support you and your family. The information you provide will be used by your health care team to develop a plan to help you maintain or improve you and your family's health and well-being in the areas that you choose.

Parents' Marital Status? \_\_\_\_\_

Current living situation?  House  Apartment  Foster care  Temporarily staying in a shelter or homeless  
 Other \_\_\_\_\_

Who do you/your child live with (check all that apply)?  Mother  Father  Step-Parent  Grandparent  
 Aunt/Uncle  Foster family  Sibling(s)  Other \_\_\_\_\_

Do you have problems with pests, mold, or a lack of heat, water or other utilities where you live? Yes  No

Within the past 12 months, my household or I were worried whether our food would run out before there was money to buy more.  Often true  Sometimes true  Never true

In the past 12 months, a lack of transportation has kept me from medical appointments or from doing things needed for daily living.  Often true  Sometimes true  Never true

Any special dietary needs (i.e. Gluten Free)? Yes  No  If yes, please specify: \_\_\_\_\_

Are you interested in getting help with parenting skills? Yes  No

### **Safety**

Is there anywhere you feel you/your child are unsafe? Yes  No  If yes, please specify: \_\_\_\_\_

Is your home "child proofed"? Yes  No

Is there anyone in the house who uses recreational drugs? Yes  No

Does anyone smoke at home (inside or outside)? Yes  No

### **Education and Activity**

Grade in School \_\_\_\_\_ Name of School \_\_\_\_\_

School Performance:  At Grade Level  Above Grade Level  Needs Assistance

Sports?  Yes  No \_\_\_\_\_ Hobbies?  Yes  No \_\_\_\_\_

Any problems with bullying?  Yes  No

Screen Time (TV/Computer/Phone) daily (on average)?  None  Less than one hour  1-2 hours  3 hours or more

How much time is spent outside daily (on average)?  None  A few minutes  One hour  More than one hour

**\*For ages 12-17 only\*** Who is filling out this portion of the form? \_\_\_\_\_

**Smoking Status:**  Never smoked  Former smoker  Current every day smoker  Current some day smoker

Tobacco years of use: \_\_\_\_\_ How many packs/day: \_\_\_\_\_

Do you use any other forms of Tobacco? Yes  No  Do you use E-cigarettes? Yes  No

**Is there anything else we have missed that you feel we should know?**

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Thank you!