Seattle Healing Arts
9730 3rd Ave NE, #208, Seattle, WA 98115
Tel: (206) 522-5646

PATIENT REGISTRATION

Please fill out completely

Last Name: MI: First Name: Age: Gender: Female Male

Street Address: City: State: Zip Code:

E-mail Address: Date of Birth: Drivers Lic #:

Daytime Tel #: ( ) MSG Okay: Y N Evening Tel #: ( ) MSG Okay: Y N

Preferred Form of Contact: ( ) E-mail ( ) Day Phone ( ) Evening Phone

Race: ( ) AA/ Black ( ) Asian ( ) Hispanic ( ) White ( ) Declined to Specify

Ethnicity: ( ) Hispanic/ Latino ( ) Not Hispanic/ Latino ( ) Declined to Specify

Employment: ( ) Employed ( ) F/T Student ( ) P/T Student ( ) Retired ( ) Other (specify):

Employer: Tel. #:

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Dependent ( ) Partnered ( ) Other

Responsible Party/ Guarantor: Phone: ( )

Emergency Contact: Phone: ( ) Relationship:

Referred By:

PRIMARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth:**

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

SECONDARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth:**

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: **Date:**

(Please Print) This information will be contained in your confidential medical history (Please Print)

HEALTH HISTORY

Name (Last, First, Middle)	Age	Today's Date

PLEASE STATE YOUR CHIEF CONCERNS, MAIN PROBLEM, OR REASON(S) FOR SEEING THIS DOCTOR:

How would you rate your general health? Excellent Good Fair Poor (why?)

PAST MEDICAL HISTORY

☐ Allergies/Hay Fever	☐ Depression	☐ Anxiety	☐ Gout
☐ Arthritis	☐ Suicide	☐ Intestinal Problems	☐ Rheumatic Fever
☐ Asthma/Emphysema	☐ Glaucoma	☐ Kidney Stones/Disease	☐ Blood Clots
☐ Bladder/Kidney Infection	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Seizure/Epilepsy
☐ Bleeding/clotting	☐ Heart Failure	☐ Liver Problem	☐ Sexually Transmitted Disease
☐ Cancer	☐ Heart Murmur	☐ Abnormal PAP	☐ Thyroid Problems
☐ Diabetes	☐ Heart Surgery	☐ High Cholesterol	☐ Tuberculosis
☐ Angina	☐ High Blood Pressure	☐ Reflux Disease	☐ Other ________

Hospitalizations or Surgeries:	Age	Date

Please list all with dose, frequency, date started, and reason (use back of form for additional space)

MEDICATIONS AND SUPPLEMENTS

Prescription Drugs	Supplements

WELL BEING

Goals for health:

What practices or activities do you use to sustain your health and well being?

Who do you turn to for support? Who are in your community?

What causes stress for you?

HEALTH HISTORY (page 2)

(Circle all that apply)

HABITS

Diet: Vegan Vegetarian Omnivore Fast Foods Other:

Alcohol: Never Occasional Moderate Heavy Specify Type: Wine Beer Hard liquor Other
Is your alcohol use ever a concern for you or others? No Yes (explain):

Tobacco: Never Current Prior (Date last used): Cigarettes - # Packs/Day? # of years?

Cigars: #/day? # of years? Chewing Tobacco: How often? How long?
Are you interested in quitting? Yes No

Caffeine: None Chocolate Coffee Tea | # cups/day: | Soda drinks, # cans/bottles/day:

Exercise: Rarely Occasional Moderate Often Favorite Types:

How long: **How Often:**

Do you use recreational drugs? Y N If yes, what type? How often?

Occupational Exposures: Asbestos Other (describe)

Drug Allergies (list all drug allergies and type of reaction):

Food Sensitivities (list all foods and type of reaction):

Latex Allergy Yes No **Allergy to I.V. Contrast Yes No**

Height: ______ft _____inches **Weight:** ______lbs Weight age 20: ______Weight change last year: gain ___lbs lost _____lbs Do you have concerns about your weight? No Yes (explain):

Your current sex partner(s) are: Male Female Both None
Are you interested in being screened for sexually transmitted disease: Yes No

FAMILY HISTORY

	Living? Y or N	Age now (or at time of death)	Major Illnesses and Cause of Death
Mother			
Father			
Brother(s) #:			
Sisters(s) #:			
Children #:			

Family History (please check all that apply and relation to you, e.g. F, M, GM, GF, B, S, C, etc):

	Alcohol Problem		Diabetes		↑Cholesterol		Osteoporosis		Prostate Cancer
	Drug Problem		Heart Attack		Hyperthyroid		Smoking.Hx		Colon Cancer
	Allergies/Hay Fever		Heart Failure		Hypothyroid		Stroke		Other Cancer
	Autoimmune Disease		Heart Surgery		Glaucoma		Suicide		Breast Cancer
	Bleeding/Clotting		High Blood Pressure		Obesity		Tuberculosis		
	Early Heart Attack (Female 65 y.o. or less, Male 55 y.o. or less)				Depression/other mental/emotional disorder				
	Other:				Other:				

SOCIAL HISTORY

Birthplace:	Education:	Occupation:

Marital Status: ( )Single ( ) Married ( ) Divorced ( ) Partnered ( ) Other (describe)

Who lives in your household?

Number of children in your household:

Do you have pets in your household? No Yes (what kind):

Some people can by hurt or threatened by people they love. Is this happening to you No Yes (details)

Is violence at home a concern for you? No Yes

HEALTH HISTORY (page 3)

(Please check any significant problems)

SYSTEM REVIEW

	Fatigue		Frequent cough		Bursitis/Tendonitis		Liver disease
	Weakness		Coughing up blood		Neck pain		Gall bladder issues
	Weight problem		Coughing up phlegm		Back pain		Sugar in urine
	Fluid retention		Frequent chest cold		Hernia		Urination problems
	Tire easily		Bronchitis		Food intolerance		Skin problems
	Headache		Pneumonia		High blood sugar		Easy bruising
	Migraine		Shortness of breath		Low blood sugar		Anemia
	Fainting		Wheezing		Indigestion		Infertility
	Dizziness		Pleurisy		Heartburn		Sexual difficulty
	Ear/hearing problem		Chest pain		Ulcers		Nervous/anxious
	Ringing in the ears		Chest tightness/pressure		Vomiting blood		Tense/irritable
	Stuffy nose		Heart Palpitations		Black/bloody stool		Insomnia
	Nose bleeds		Enlarged heart		Rectal bleeding		Relationship problems
	Sinus problems		Leg pain on walking		Abdominal pain		Job problems
	Persistent hoarseness		Restless legs at night		Spastic colon		Personal problems
	Glasses		Leg cramps		Colitis		Decreased appetite
	Vision/Eye problems		Phlebitis		Diarrhea		Seen a psychiatrist/therapist
	Glaucoma		Varicose Veins		Constipation		Nervous breakdown
	Cataract		Shortness of breath on exertion		Change in bowel habits		Changing mole
	Swallowing trouble		Ankle/leg swelling		Hemorrhoids		**OTHER:**
	Fever		Joint pain/swelling		Night sweats		
	Excessive thirst		Excessive urination		Heat or cold intolerance		

	MEN ONLY		WOMEN ONLY
	Prostate trouble		Age at 1st period: _________ Periods: ( ) N/A ( )Regular ( )Irregular ( )Painful ( )Heavy Every ______ days Last menstrual period: date(s)
	Date of last prostate exam/result:		( )Menopausal Age at menopause: Do you have concerns about Menopause? No Yes (explain):
	Stream weak or slow		Date of Last PAP: ( ) Normal ( ) Abnormal (explain):
	Pain/swelling in testes		Date of Last Mammogram: ( ) Normal ( ) Abnormal (details):
	Discharge from penis		If sexually active, method used to prevent pregnancy:
	Erectile problems		# of Pregnancies: # of Births: # of Miscarriages/abortions:
	Any other issues?:		Age of first pregnancy:
			Any other issues?:

PREVENTIVE CARE

Indicate whether you have had any of the following by listing dates

	Date		Date	
Last Physical Exam		Hepatitis B Vaccine		Do you have guns in your home? No Yes
Last Dental Exam		Tetanus Booster		Do you wear seatbelts? No Yes Occ
Last Eye Exam		Pneumonia Vaccine		Do you wear a bicycle helmet? No Yes
Last Chest X-Ray		PPD (TB skin test)		
Last EKG		Mammogram		
Osteoporosis screening (Dexascan)		Stool Test for Blood		
Flu Shot		Colonoscopy		
Varicella (Chickenpox) Vaccine		Cholesterol tests		
Measles/Mumps/Rubella Vaccine		HIV/AIDS test		

Mary G. Bolton, MD, PhD
Seattle Healing Arts Center, 9730 3rd Ave NE, Suite #208, Seattle, WA 98115
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NOTICE TO PATIENTS REGARDING WELL EXAMS

If you schedule an annual exam, PAP or physical, your insurance company may call this visit "preventative", "yearly", or "annual". Please take a moment to read the remainder of this letter.

Due to national coding laws, we must bill your insurance company for your exam as a preventative care visit. If during your visit you have additional concerns or conditions that require diagnosis and treatment, you may incur additional office or lab charges. These charges will be submitted to your insurance company as well as the preventative visit. If your insurance company does not cover some or all of the charges, you will be billed for the balance that your insurance company indicates as patient responsibility. Please do not ask us to re-bill by changing a procedure or diagnostic code. By asking this of your physician, you are asking him/her to commit insurance fraud.

Medicare Patients

Please be aware of your insurance coverage and benefits. If preventative care coverage is not part of your insurance benefits, we may ask for payment at the time of service. If you are experiencing financial hardship, we can assist you with payment options. Insurance plans do not cover DOT (Department of Transportation) exams or most other exams done purely for administrative purposes such as immigration/emigration, adoption, college entrance and others. In certain cases, those forms may be completed as a part of a routine physical examination, but not always. Please ask your physician if you have any questions.

Please be aware that the Initial Physical Examination (IPPE) also known as the "Welcome to Medicare" visit is not the "routine physical checkup" that some seniors may receive every year or two from their providers. Medicare DOES NOT provide coverage for routine physical exams. An IPPE consist of a history, medication review, fall risk screening, depression screening and vital signs. An EKG may be done and will be billed separately. Laboratory testing is not part of the service and is ordered and billed separately. Coverage of the IPPE visit is provided as a Medicare Part B benefit. The Medicare deductible is waived for the IPPE. A patient may have one IPPE exam in a lifetime and it must be done within one year of becoming eligible for Medicare. If you are here for the "Welcome to Medicare" JPPE, please be sure to tell your physician.

Thank you for your understanding in this matter. Your cooperation is greatly appreciated.

Signature ______________________ Date of Birth ______________________

Please print name ______________________ Date ______________________

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MEDICATION HISTORY AUTHORITY

I give Mary G. Bolton MD, PhD my permission to retrieve my medication history as provided by my insurance company.

Background: This feature allows us to fill in your medication history, cross-reference and verify which medications you are taking, create a more accurate history, be more aware of interactions, and prescribe you more safely.

______________________________ ____________________
Patient Signature Date

RELEASE OF BILLING INFORMATION

I hereby give permission to my physician to submit health information to my insurance plan in order to receive payment for services rendered.

Background: Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

______________________________ ____________________
Patient Signature Date

ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for any balance.

______________________________ ____________________
Patient Signature Date

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CANCELLATION POLICY

Our practice provides a unique clinical experience and we value the depth of the relationship that we build with the people we serve. To that end, we generally spend significantly more time during each patient visit than is standard in health care today.

We require at least 24 hours' notice for cancellations so that we may offer that appointment to another patient in our community. The 24 hour notice excludes weekend hours. If you need to cancel an appointment for Monday, please call on Thursday of the preceding week. Appointments can also be requested and cancelled online through your Care Cloud Portal. The link for this portal is: http://community.carecloud.com/

The charge for a missed appointment or late cancellation is $100. The fee will not be covered by your health plan.

Reminder calls and emails are often done as a courtesy to patients, but we do not guarantee that you will receive a call. Please ask for appointment reminder card if needed.

I, the undersigned, have read and had an opportunity to ask questions about this Late Cancellation and Missed Appointment Policy. I understand and agree to the contents of the policy.

________________________________ __________________
Patient/ Guardian Signature Date

____
Please Print Name

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NOTICE OF PRIVACY PRACTICE- ACKNOWLEDGEMENT

We keep a record of health services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting your practitioner.

We have a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how. can access your health care information, and whom to contact if you have questions, concerns, or complaints.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. We may change the Notice of Privacy Practice at any time.

If you have any questions, you can contact Spencer Haugen, Privacy Officer at 206-522-5646.

By my signature below I acknowledge that I have reviewed the Notice of Privacy Practices and that a copy has been provided if I have requested one.

____

Printed name of patient

______________________________ Date__________

Patient or legally authorized individual's signature

____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: ______________ Staff member initials: ______________

Reasons: