( ) Karim Abdullah, ND, Lac
( ) Dean Chier, MD
( ) Amy Hobson, ND

Seattle Healing Arts Center

6300 9th Ave NE, #200 Seattle, WA 98115
Tel: (206) 522-5646
Fax: (206) 524-5051

Martina Koller, MD (X)
W. Bruce Milliman, ND ( )
Fernando Vega, MD ( )

PATIENT REGISTRATION

Please fill out completely

First Name: _____ MI: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ D.O.B: _____

Employer: _____ Mobile Phone #: ( ) _____ MSG Okay: ( ) YES ( ) NO

Gender Identity: ( ) Male ( ) Female Home Phone #: ( ) _____ MSG Okay: ( ) YES ( ) NO

Work Phone #: ( ) _____ MSG Okay: ( ) YES ( ) NO

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

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

Responsible Party: _____ Phone: ( ) _____

Address: _____ City, ST, ZIP: _____

Emergency Contact: _____ Phone: ( ) _____

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 assesed 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:** _____

ADULT HEALTH HISTORY

Name:_____ Today's Date:_____

Does your insurance cover physicals/preventive care? ☐ yes ☐ no ☐ I don't know

Your answers on this form will help your provider better understand your medical concerns and conditions. This form will be put in your medical record. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Age:_____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PRESENT HEALTH CONCERNS:_____

_____

ALLERGIES/REACTIONS TO MEDICINES:_____

_____

CURRENT MEDICATIONS: (Please include dose of Medicines/Vitamins/Supplements/Over the Counter Medicine/Birth Control Pills)

1)_____ 5)_____
NAME -- DOSE -- NAME DOSE

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

PAST MEDICAL HISTORY: Indicate whether you have had any of the medical problems listed below by listing dates.

_____Alcohol/Drug Problem
_____Allergies/Hay Fever
_____Arthritis
_____Asthma/Emphysema
_____Bladder or Kidney Infection
_____Bleeding/clotting
_____Cancer
_____Osteoporosis
_____Diabetes
_____Depression/suicide attempt
_____Glaucoma
_____Heart disease/heart attack
_____High blood pressure
_____High cholesterol
_____Kidney Stones
_____Liver problem
_____Seizures
_____Sexually Transmitted Disease
_____Stroke
_____Thyroid condition
_____Tuberculosis
_____Other_____

SURGERIES/HOSPITALIZATIONS: Indicate whether you have had any surgery or hospitalizations by listing dates:

1)_____ 4)_____
SURGERY DATE SURGERY DATE

2)_____ 5)_____

3)_____ 6)_____

FAMILY HISTORY:

	Living?	Age now or at death	Major illnesses/cause of death
Mother:			
Father:			
Sister(s): #_____			
Brother(s): #_____			

HABITS:

Do you EXERCISE regularly? ☐ yes ☐ no What kind of exercise? _____ How long (minutes)? _____ How often? _____	How would you rate your DIET? ☐ good ☐ fair ☐ poor Are you satisfied with your weight? ☐ yes ☐ no
CAFFEINE intake: ☐ none ☐ coffee/tea _____ cups/day ☐ chocolate _____ ☐ soda drinks _____ cans/bottles/day	Do you drink ALCOHOL? ☐ no ☐ yes Drinks/week _____ Is your alcohol use a concern for you or others? ☐ yes ☐ no
Do you use TOBACCO now? ☐ no ☐ yes cigarettes/day _____ For how long? _____ Are you interested in quitting? ☐ yes ☐ no	Do you use TOBACCO previously? ☐ no ☐ yes cigarettes/day _____ For how long? _____ Are you interested in quitting? ☐ yes ☐ no
Do you use RECREATIONAL DRUGS? ☐ no ☐ yes: _____	
Your current sex partner(s) is/are: ☐ male ☐ female ☐ both ☐ none Are you interested in being screened for sexually transmitted diseases: ☐ no ☐ yes	

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

Complete physical exam _____	TB skin test (PPD) _____	Osteoporosis screening (Dexascan) _____
Tetanus booster _____	Flu Shot _____	Exam by eye doctor _____
Chickenpox illess/Varicella Vaccine _____	Rectal examination _____	Dental Checkup _____
Measles/mumps/rubella vaccine _____	Stool test for blood _____	HIV/AIDS test _____
Pneumonia vaccine _____	Colonoscopy _____	_____
Hepatitis B vaccine _____	Cholesterol Tests _____	_____

SOCIAL HISTORY:

Birthplace: _____ Education: _____ Occupation: _____

Relationship/marital status: _____ Number of children/ages: _____

Who lives at home with you? _____

Some patients can be hurt or threatened by someone they love. Is this happening to you? ☐ no ☐ yes Details: _____

Is violence at home a concern for you? _____

WOMEN'S HEALTH HISTORY:

First day of most recent menstrual period: _____

Do you have concerns about your periods? ☐ no ☐ yes Details: _____

Age at first period: _____ Frequency of periods: _____ Duration of periods: _____

Total # pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Date of last PAP SMEAR: _____ History of abnormal Pap smear? ☐ no ☐ yes Details: _____

Date of last MAMMOGRAM: _____ History of abnormal mammogram? ☐ no ☐ yes Details: _____

If sexually active, method used to prevent pregnancy: _____

Do you have concerns about menopause? ☐ no ☐ yes: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of health care services we provide you. You may ask to see and copy 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 authorizes or compels us to do so. You may see your record or get more information about it by contacting your practitioner.

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.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized signature Date

_____ _____

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

Seattle Healing Arts
Practice Information and Patient Responsibility Agreement

We ask that every patient please read and agree to the following:

- **Please be prepared to provide identification and insurance card at the time of each visit.**

- Each practitioner operates individually as a private practice. Practitioners maintain separate charts, registration forms, insurance information, monies, etc. Updating your information for one practitioner does not update the chart of any other practitioner.

- **We require 24-hour notice of appointment cancellations.** A patient may be subject to a cancellation fee if proper notice is not given.

- **Each patient is responsible for knowing the terms and coverage of their own insurance plan.** If you have insurance and your practitioner "accepts" that insurance, that does not guarantee payment will be made from your insurance company. You are then personally responsible for the bill.

- **Please notify the front desk if you have Medicare.** Several physicians are not signatory to Medicare and most supplemental insurances will not cover visits made to a non-Medicare provider. Medicare and insurance information is still required to be on file for laboratory charges.

- Seattle Healing Arts is not an urgent-care or drop-in clinic. Patients are seen by appointment. If your practitioner is not in the office, the Front Desk can refer you to a covering physician or the on-call physician number is available through the phone service.

- **Dispensary items must be obtained by your practitioner or with a written prescription from your doctor. If a refill is needed, please contact your practitioner and allow 48 hours for adequate processing time.**

- Payment for dispensary items and co-pays needs to be completed at the time of service. **Exact change, check or Visa/MasterCard is required.**

- Seattle Healing Arts is a **fragrance-free facility** and only allows service animals in the building. Please help us maintain an allergy free environment.

Patient_____Date_____

Seattle Healing Arts

NOTICE TO PATIENTS REGARDING WELL EXAMS

For many patients, it is recommended to schedule an occasional preventative care appointment, or physical exam. A routine preventative exam is technically defined as "periodic comprehensive preventative medicine evaluation and management" and includes the following:

- Past medical, social and family history
- Complete physical exam and review of body systems
- Review of medications, immunizations, counseling/anticipatory guidance/risk factor reduction interventions
- Review of age/gender appropriate screening tests

This exam is prevention focused, not problem focused. If you choose to bring up an additional health concern or treatment, the visit may incur additional coding and charges.

Due to national coding laws, all appointments must be billed according to what transpires in the appointment. If you receive a bill for additional treatment following your scheduled physical, please do not ask us to re-bill by changing a procedure or diagnostic code. By asking this of your provider, you are asking him/her to commit insurance fraud.

Thank you for your understanding. Your cooperation is greatly appreciated.

Name _____ Date of Birth _____

Signature _____ Date _____