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Seattle Healing Arts

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PATIENT REGISTRATION

Please fill out completely

First Name: **MI:** **Last Name:**

Street Address:

City: **State:** **Zip:**

Email:

Date of Birth: **Mobile Phone #: ( )** **MSG Okay: ( ) YES ( ) NO**

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

Employer: 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 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

SEATTLE HEALING ARTS HEALTH HISTORY

Name (first, middle, last)	Age:	Today's Date:

Please give names and dates

PAST HISTORY

Major Illnesses:

Medications:

previous hospitalizations or surgeries:

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?

Who lives in your household?

What causes stress for you?

DIET: ___Fast Food ___All American ___Vegetarian ___Balanced ___Other ___________

SMOKING: Packs per day ________ Number of years ________ Years stopped ________ Pipe Cigar Chew

ALCOHOL: Never Occasional Moderate Heavy Alcohol Problem? Y N How much each week?

EXERCISE: Never Occasional Moderate Often Favorite types?

CAFFEINE: Coffee: _____ cups per day Tea: _____ cups per day

Height: ________ Weight ________ Weight at age 20 ________ Weight change last year: gain ________ lbs. lost ________ lbs.

OCCUPATIONAL EXPOSURES: _____ Asbestos _____ Other (describe)

DRUGS: Please check off drugs presently used and explain frequency of use (daily, weekly, etc.)

	Sleeping pill		Allergy medicine(s)		Blood thinner		Antibiotics
	Tranquilizer		Nose sprays		"Hard drugs"		Asthma medicine
	Anti Depressant		Cortisone/steroids		Marijuana		Shots
	Pain pill		Thyroid		Cocaine		Other(s) - Specify
	Diet pill		Heart pill		Laxative		
	Diabetes pill		Digitalis		Antacids		
	Estrogen hormone		Nitroglycerin		Decongestant		
	Birth control pill		Water pill (diuretic)		Vitamins		
	Insulin		Blood pressure pill		Iron		

ALLERGIES:

Food sensitivities:

Drug allergies/Type of reaction:

FAMILY HISTORY:		CHILDRENS AGES/NAMES	
	Diabetes		
	Heart disease		
	High blood pressure		
	Thyroid		
	Stroke		
	Cancer		
	Alcoholism		

SEATTLE HEALING ARTS HEALTH HISTORY - PAGE 2

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

SYSTEM REVIEW: Check if you have any symptoms or problems to any important or significant degree.

	Tired all the time		Frequent chest colds		Indigestion		Sugar in urine
	Don't feel well		Bronchitis		Heartburn		Hypoglycemia
	Weakness		Pneumonia		Nervous stomach		Low blood sugar
	Weight problem		Shortness of breath		Ulcers		Thyroid trouble
	Fluid retention		Asthma/wheezing		Vomiting blood	DATE OF last urinary or bladder infection:	
	Lack of exercise		Hayfever		Black or bloody stools		
DATE OF LAST PHYSICAL EXAM:			Pleurisy		Rectal bleeding		Bladder problems
			Chest pain		Abdominal pain		Kidney infection
	Headache		Heart trouble		Nervous or spastic colon		Kidney trouble
	Migraine		Heart murmur		Colitis		Kidney stone
	Fainting		Heart palpitation/racing		Diarrhea		Difficulty with urine
	Dizziness		Chest tightness/pressure		Constipation		Protein or blood in urine
	Epilepsy/seizure		Angina		Change in bowel habits		Sexually transmitted disease
	Ear/hearing problem		Tire easily		Hemorrhoids		Skin rash
	Ringing in the ears		Enlarged heart		Gall bladder trouble		Skin trouble
	Stuffy nose		Rheumatic fever		Hepatitis		Allergy
	Nose bleeds		Leg pain on walking		Liver disease		Food avoidance
	Sinus trouble		Varicose veins		Hernia		Bleed or bruise easily
DATE OF LAST DENTAL EXAM:			Phlebitis		Food intolerance		Anemia
			Ankle/leg swelling		Nervous		Blood disease
	Persistent hoarseness	DATE OF LAST CHEST X-RAY:			Tense/irritable		Infertility problem
	Glasses				Bored		Sexual difficulty
	Vision/eye trouble	DATE OF LAST Electrocardiogram:			Depressed		
	Glaucoma				Trouble sleeping	**MEN ONLY:**	
	Cataract		Arthritis/joint pain		Relationship problems		Discharge from penis
DATE OF LAST EYE EXAM:			Gout		Job problems		Prostate trouble
			Neck pain		Personal problems		Stream weak or slow
	Frequent cough		Back pain or trouble		Nervous breakdown		Swelling or pain in testes
	Cough phlegm		Bursitis/tendentious		Psychiatrist seen	DATE OF VASECTOMY:	
	Cough blood		Swallowing trouble		High blood sugar		

WOMEN ONLY:

Age menstruation began: __________ Periods: ____Regular ____Irregular ___Painful ___Heavy Every____________days

Comments: Last menstrual period date(s):__________

Number of PREGNANCIES:____ Number of BIRTHS:____ Number of Miscarriages/Abortions:____

Dates of PREGNANCIES / outcome:

Type of birth control: ____________________ How Long?_______ IUD? ____Yes ____No Years inserted ____________

Date of last mammogram ________________ History of breast disease?

Symptoms of menopause?

(Additions to health history)

Please complete other side

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 ___________________________