

BIRTH & FAMILY CLINIC21911 76th Ave. W., Suite 110 Edmonds, WA 98026
Phone: 425-640-4950 Fax: 425-640-4958**Patient Registration Information**

Please Print

Patient Name:			
Previous Name/Name Change:			
Birth Date:	Age:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Soc. Sec. # - -
Phone: ()	Cell: ()	Work: ()	
Mailing Address:			
Street		City	State Zip
Billing Address (If other than mailing):			
Street		City	State Zip
PARTY RESPONSIBLE FOR PAYMENT (If other than patient):			
Name		Relationship to Patient	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Live with Partner <input type="checkbox"/> Other:			
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other:			Language:
In case of emergency notify:			
Name		Relationship to Patient	Phone: ()

INSURANCE INFORMATION – PLEASE GIVE YOUR CARD TO RECEPTIONIST FOR COPYING/SCANNING

PRIMARY INSURANCE:		Policy #	Group #
Policy Holder's Name	Relationship to Patient	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
SECONDARY INSURANCE:		Policy #	Group #
Policy Holder's Name	Relationship to Patient	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the healthcare provider as well as release of any information by provider or insurance company required for this account. Release of information to include: (1) alcohol and/or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Disease), and (4) treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions. I hereby release Birth & Family Clinic from all legal responsibility or liability that may arise from disclosure of my record as provided by this paragraph. Payment: I am financially responsible for any balance due. I agree to make payment arrangements; pay \$5 or 1% interest per month (whichever is greater) on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

X _____ DATE
Patient or Patient Representative SIGNATURE

Last Name _____ First _____ MI. _____ Date of Birth _____ Age _____ Today's Date _____

Infection Exposure	No	Yes	Don't Know
1. Are you concerned you might have HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you concerned you might have hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel you are at risk for HIV based on blood transfusion before 1990, injection drug use, or sexual preference?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had intimate contact with someone known to have HIV or other STDs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preventive Care	No	Yes	Date	Where	Immunizations	No	Yes	Date
Last Complete Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>			Flu Shot	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Blood Work	<input type="checkbox"/>	<input type="checkbox"/>			H1N1	<input type="checkbox"/>	<input type="checkbox"/>	
Last Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>			Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
Last Dental Visit	<input type="checkbox"/>	<input type="checkbox"/>			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>			Zostavax	<input type="checkbox"/>	<input type="checkbox"/>	
DEXA (Bone Density)	<input type="checkbox"/>	<input type="checkbox"/>						
What other practitioners do you see?								

Review of Systems

Circle any symptoms you are currently experiencing: None

<p>General</p> <ul style="list-style-type: none"> fevers chills drenching night sweats loss of appetite fatigue unexpected weight loss trouble sleeping severe snoring daytime sleepiness <p>Eyes</p> <ul style="list-style-type: none"> loss of vision double vision eye irritation blurred vision eye pain eye discharge light sensitivity <p>Ears, Nose & Throat</p> <ul style="list-style-type: none"> ringing in the ears ear discharge earache decreased hearing nasal congestion nasal discharge nosebleeds face or jaw pain difficulty swallowing hoarseness sore throat <p>Cardiovascular</p> <ul style="list-style-type: none"> difficulty breathing at night fainting or near fainting chest pain palpitations or racing heart short of breath with exertion swelling in extremities difficulty breathing lying down 	<ul style="list-style-type: none"> calf pain with walking recent weight gain <p>Respiratory</p> <ul style="list-style-type: none"> cough short of breath coughing up blood chest pain with deep breaths wheezing (asthma) excessive mucus or phlegm <p>Gastrointestinal</p> <ul style="list-style-type: none"> heartburn indigestion vomiting vomiting blood nausea abdominal pain abdominal bloating diarrhea change in bowel movements constipation black tarry stools rectal bleeding/blood in stools <p>Genitourinary</p> <ul style="list-style-type: none"> blood in urine urinary frequency urinary urgency burning or pain with urination urinary incontinence genital sores decreased sex drive <p>Women Only-Genitourinary</p> <ul style="list-style-type: none"> hot flashes pain with intercourse irregular or missed periods heavy periods prolonged periods painful periods 	<ul style="list-style-type: none"> spotting vaginal discharge pelvic pain <p>Men Only-Genitourinary</p> <ul style="list-style-type: none"> trouble starting urination weak or narrow urine stream dribbling after urination incomplete emptying frequent nighttime urination discharge from penis problems with erections testicular pain or lump <p>Musculoskeletal</p> <ul style="list-style-type: none"> muscle cramps joint pain joint swelling back pain stiffness general weakness muscle aches <p>Skin/Breasts</p> <ul style="list-style-type: none"> excessive perspiration suspicious mole or growth change in hair or nails non-healing sores dry skin itching rash breast pain breast lump nipple discharge <p>Neurological</p> <ul style="list-style-type: none"> trouble concentrating poor balance or coordination headaches facial weakness 	<ul style="list-style-type: none"> numbness or tingling slurred speech falling down visual disturbances seizures arm or leg weakness sensation of spinning tremors loss of consciousness confusion uncontrolled movements dizziness poor memory <p>Mental Health</p> <ul style="list-style-type: none"> fears or phobias anxious mood thoughts of suicide depressed mood thoughts of violence to others frightening visions or sounds <p>Endocrine</p> <ul style="list-style-type: none"> excessive hunger intolerance to cold intolerance to heat excessive urination excessive thirst <p>Blood</p> <ul style="list-style-type: none"> enlarged glands prolonged bleeding excessive or easy bruising <p>Allergy & Immunology</p> <ul style="list-style-type: none"> persistent infections hives seasonal allergies possible HIV exposure
---	---	--	--

Rev. 03/2011

X

SIGNATURE

DATE