

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

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Acknowledgment of Receipt of Privacy Notice

Patient Name (Please PRINT)

Date of Birth

1. With my initials below, I acknowledge that I was offered and/or provided with a copy of the Notice of Privacy Practices for Birth & Family Clinic.

Initial Here: []

2. I authorize Birth & Family Clinic to contact me with my **CONFIDENTIAL** information regarding treatment or test results at the following numbers:

Please leave at least one number where we could leave you a message.

- Home Number: () Voicemail OK? Yes No
- Cell Number: () Voicemail OK? Yes No
- Work Number: () Voicemail OK? Yes No

3. I authorize Birth & Family Clinic to discuss my protected health information, including medical history, current conditions, treatment, and test results with the following individuals:

- Patient Only**
- Spouse or Significant Other**
Name: _____
- Parent(s)**
Name: _____
Name: _____
- Other**
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

4. I authorize Birth & Family Clinic to discuss my billing information with the above noted individuals.

- Yes No

X _____
Signature Relationship to Patient Date

This authorization is valid for one year (1) following the date signed above unless withdrawn in writing to Birth & Family Clinic.

Health History Form

Swedish/Edmonds

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

*New Patients: How did you hear about us? Facebook Friends/Family Internet Phone Book Other: _____

Main reason for today's visit: _____

Other concerns I would like to discuss if there's time: _____

Medical History	Problem	Onset Date	Surgeries/Hospitalizations		Hospital
			Year	Type <input type="checkbox"/> None	

Medications <input type="checkbox"/> None	Allergies to Medications <input type="checkbox"/> None
List prescriptions, vitamins, supplements & over the counter medications.	List the drug and the reaction you had.
	Other Allergies: _____

Women Only	# Pregnancies	# Vaginal Deliveries	# C-Sections	# Miscarriages	# Terminations
Date of Last Period:		Period Frequency:		Birth Control Method:	
Last Pap Smear:		History of Abnormal Pap Smear(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Last Mammogram:		Do you do self breast exam?	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Family History	Please indicate family members (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:	First Name	Age Now	Age at Death
Alcoholism	Mental Illness (list type)			
Arthritis	Migraine			
Asthma	Obesity	Siblings: <input type="checkbox"/> None		
Breast Cancer	Osteoporosis			
Colon Cancer	Ovarian Cancer			
Diabetes	Prostate Cancer	Children: <input type="checkbox"/> None		
Glaucoma	Stroke			
Hay Fever	TB			
Heart Disease	Ulcer Disease			
High Blood Pressure	Other:			
High Cholesterol				

Social History	Do You Have	No	Yes
Education: <input type="checkbox"/> Grade <input type="checkbox"/> H.S. <input type="checkbox"/> Voc. <input type="checkbox"/> College <input type="checkbox"/> Advanced Degree	Living Will	<input type="checkbox"/>	<input type="checkbox"/>
Employment Status: <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Working	Durable Power of Attorney	<input type="checkbox"/>	<input type="checkbox"/>
Occupation: _____	Spouse's/Partner's Name: _____		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Live with Partner			

Risk Factors	No	Yes						
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Year Started:		Year Quit:			
			<input type="checkbox"/> Cigarettes					
Passive Smoke Exposure	<input type="checkbox"/>	<input type="checkbox"/>						
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Type:		# Drinks:			
Recreational Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana <input type="checkbox"/> Other:					
Caffeine Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coffee <input type="checkbox"/> Cola <input type="checkbox"/> Tea					
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Type:					
Seatbelt Use	<input type="checkbox"/>	<input type="checkbox"/>						
Sun-Block Use	<input type="checkbox"/>	<input type="checkbox"/>						

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Over – Complete Other Side

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 fevers chills drenching night sweats loss of appetite fatigue unexpected weight loss trouble sleeping severe snoring daytime sleepiness</p> <p>Eyes loss of vision double vision eye irritation blurred vision eye pain eye discharge light sensitivity</p> <p>Ears, Nose & Throat ringing in the ears ear discharge earache decreased hearing nasal congestion nasal discharge nosebleeds face or jaw pain difficulty swallowing hoarseness sore throat</p> <p>Cardiovascular 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</p>	<p>calf pain with walking recent weight gain</p> <p>Respiratory cough short of breath coughing up blood chest pain with deep breaths wheezing (asthma) excessive mucus or phlegm</p> <p>Gastrointestinal 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> <p>Genitourinary blood in urine urinary frequency urinary urgency burning or pain with urination urinary incontinence genital sores decreased sex drive</p> <p>Women Only-Genitourinary hot flashes pain with intercourse irregular or missed periods heavy periods prolonged periods painful periods</p>	<p>spotting vaginal discharge pelvic pain</p> <p>Men Only-Genitourinary 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> <p>Musculoskeletal muscle cramps joint pain joint swelling back pain stiffness general weakness muscle aches</p> <p>Skin/Breasts 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> <p>Neurological trouble concentrating poor balance or coordination headaches facial weakness</p>	<p>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> <p>Mental Health fears or phobias anxious mood thoughts of suicide depressed mood thoughts of violence to others frightening visions or sounds</p> <p>Endocrine excessive hunger intolerance to cold intolerance to heat excessive urination excessive thirst</p> <p>Blood enlarged glands prolonged bleeding excessive or easy bruising</p> <p>Allergy & Immunology persistent infections hives seasonal allergies possible HIV exposure</p>
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X

SIGNATURE

DATE

BIRTH & FAMILY CLINIC

Dear Patient,

We would like to know how you found out about Birth & Family Clinic.
Could you please take a minute to answer the following questions?

How did you first hear about us?

- | | |
|--|---|
| <input type="checkbox"/> Friend/Family Referral | <input type="checkbox"/> Physician Referral |
| <input type="checkbox"/> Swedish Referral Source | <input type="checkbox"/> Current/Former Patient |
| <input type="checkbox"/> Google Ad | <input type="checkbox"/> Insurance Directory |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Website (please specify): _____ | |
| <input type="checkbox"/> Other (please specify): _____ | |

Are you here today because you are pregnant? Yes No

Please leave completed survey at the front desk.

Thank you!