

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: _____			
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:			
_____	_____	Phone: () _____	
Name	Relationship to Patient		

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

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

Pediatric Health History Form

Swedish/Edmonds

Today's Date: / /

Child's Name: _____ Child's Date of Birth: ____/____/____ Child's Age: _____
Last First MI

Parent's Name(s) _____ Names of household members: _____

Who has legal custody of the child? _____

Immunizations

Has your child had all recommended immunizations? Yes No
If no, why not? _____

Has there been any reaction to prior immunizations? Yes No
If yes, what? _____

Have all household members been immunized against pertussis (whooping cough)? Yes No

Pregnancy and Birth

1. Birth weight _____ Did the baby come on time? Yes No

2. Problems in pregnancy or labor and delivery: None

3. Smoking or alcohol during pregnancy? Yes No

4. Medications during pregnancy? None

5. Problems of baby at birth or shortly after birth: None

Child's Medical History

Current Medications (list frequency and dose): None No change
Vitamins: Yes No Fluoride: Yes No

Medication Allergies (list the drug and the reaction): None No change

Other Allergies: _____

List previous/current medical problems and when they began: No change

Previous Surgeries: _____

Previous Hospitalizations: _____

Previous Healthcare Providers: _____

The Early Years

1. Bottle fed _____ or Breast fed _____
2. Age your child: Sat alone _____ Walked _____
Spoke 10 words _____
3. Any dietary problems? _____
4. Toilet training problems? _____

PARENT SIGNATURE _____

Past Medical History

Has your child ever had (if yes, note the date):

	Yes	No	Date		Yes	No	Date
3 episodes of ear infection				Trouble sleeping			
3 throat infections in a year				Dental problems			
Convulsions				Problem with urination			
Hearing problems				Problem with bowel movements			
Anemia				Roseola			
Measles				Pneumonia			
German measles				Broken bones			
Mumps				Serious accidents			
Whooping cough				School problems			
Sleeping problems							

Family History

Have any relatives had (list the family member and the age diagnosed):

Alcohol/Drug Abuse _____	Learning problems _____
Allergies _____	Mental Illness (list type) _____
Asthma _____	Obesity _____
Breast Cancer _____	Osteoporosis _____
Colon Cancer _____	Ovarian Cancer _____
Diabetes _____	Prostate Cancer _____
Epilepsy/Seizures _____	Stroke _____
Hay Fever _____	Suicide _____
Heart Disease _____	TB _____
High Blood Pressure _____	Thyroid Problems _____
High Cholesterol _____	Other: _____

Safety

Does your child use a car seat OR a booster seat (if under 8 years old or if under 4'9")? Yes No

Does your child use a bicycle helmet? Yes No

Are there any family members who smoke? Yes No

PARENT SIGNATURE _____

CONSENT FORM FOR PARENT OF MINOR CHILD

I/We give BIRTH AND FAMILY CLINIC permission to administer to our minor child the medical treatment deemed necessary by his/her physician.

Child's Name – Please Print

Parent's Name (Signature)

Date

For whatever reason the parent/parents wish to revoke this consent, the parent could do so by notifying us in writing.