

# ❖ WELCOME ❖

**Emerald City Naturopathic Clinic, Inc. P.S. 1409 NW 85<sup>th</sup> St., Seattle, WA 98117 206-781-2206 fax: 206-783-3949**

## PATIENT INFORMATION

Last Name	_____	Social Security #	_____
First Name	_____	Sex	_____
Middle Initial	_____	Marital Status	_____
Street Address	_____	Copay	_____
City	_____	Occupation	_____
State	_____	Name of Spouse or Partner	_____
Zip	_____	Names of Children	_____
Home Phone	_____		_____
Work Phone	_____		_____
Birth date	_____		_____

## PRIMARY INSURANCE (Please present your insurance card at first visit)

Name of Insurance (Insurance Company)	_____
Type of Plan (PPO, Selections, Care, Basic Health...)	_____
Policy Number (Group #)	_____
ID number (Subscriber #)	_____

## SECONDARY INSURANCE

Name of Insurance (Insurance Company)	_____
Type of Plan (PPO, Selections, Care, Basic Health...)	_____
Policy Number (Group #)	_____
ID number (Subscriber #)	_____

## ASSOCIATIONS

Employer or school if student	_____
Primary Care Provider (physician)	_____
How were you referred to us?	<input type="checkbox"/> Physician (name): <input type="checkbox"/> Patient (name): <input type="checkbox"/> ECN Website <input type="checkbox"/> Other
Please give us information to thank your referral source:	

## CUSTOM FIELDS

Emergency contact #	Name:	Number:
Your e-mail address	_____	_____
Your cell Phone #	_____	_____
Secure message # (where we may leave a private medical message)	_____	_____

Patient Name: \_\_\_\_\_ Date of First Office Call: \_\_\_\_\_

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**REASON FOR VISIT**

Please list your present health concerns, problems or symptoms:

**PATIENT INFORMATION**

When was your last: Physical exam? \_\_\_\_\_ Blood work? \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

	Yes	No		Yes	No
<b>1. Are you currently under medical treatment?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>4. Are you currently taking any medications?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please describe:</i> _____			<i>Please describe:</i> _____		

<b>2. Have you had any serious illnesses or operations?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>5. Have you ever had a reaction to?:</b>		
<i>Please describe:</i> _____			Local anesthetics (eg. Novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>

<b>3. Women only</b>			Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
Number of Pregnancies: _____			Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
			Barbiturates (sleeping pills)	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Please Explain:</i>		

Have you ever had :	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis-Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cough-persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Any other condition	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Please describe:	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____		

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to Emerald City Naturopathic Clinic, Inc. P.S. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or the behalf of my dependants. I authorize Emerald City Clinic to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Emerald City Clinic to leave personal medical information for me on the secure phone number which I have indicated on this form.

**Signature of Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_