

❖ WELCOME ❖

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

PATIENT INFORMATION

Last Name _____	Social Security # _____
First Name _____	Sex _____
Middle Initial _____	Mother's Name _____
Street Address _____	Father's Name _____
City _____	Living with whom? _____
State _____	Siblings _____
Zip _____	
Home Phone _____	Additional Family _____
Work Phone _____	Contact Information _____
Birth date _____	You wish us to have _____

RESPONSIBLE PARTY

Person Responsible for Account _____	
Responsible Party's Social Sec.# _____	
Responsible Party's Address _____	
Responsible Party's Home # _____	Responsible Party's Work # _____

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

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

ASSOCIATIONS

School _____	
Primary Care Provider _____	
How were you referred to us? _____	<input type="checkbox"/> Physician: <input type="checkbox"/> Patient: <input type="checkbox"/> ECN Website <input type="checkbox"/> Other
Please give us information to thank your referral source: _____	

CUSTOM FIELDS

Emergency contact # _____	Name: _____	Number: _____
e-mail address (of guardian) _____		
Cell Phone # (of guardian) _____		
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? _____

Physician's name: _____ Phone #: _____

	Yes	No		Yes	No
1. Are you currently under medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	4. Are you currently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>

Please describe: _____

Please list: _____

2. Have you had any serious illnesses or operations? Yes No

Please describe: _____

5. Have you ever had a reaction to?:

- | | | |
|--|--------------------------|--------------------------|
| Local anesthetics (eg. Novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please Explain:

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 Hear 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 _____