MERIDIAN MEDICINE

2111 N. Northgate Way #201, Seattle, WA 98133
Phone 206-525-8015 Fax 206-525-8014

Patient Information:

Legal Name (Last, First, MI): _____ Today's Date:_____

Other/Maiden Name: _____Name I prefer to be called_____

Date of Birth:_____Gender at Birth:____Current/Preferred Gender:____Preferred Pronoun:_____

Address: _____City: _____ State: _____ Zip:_____

Employer/School:_____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

*I would like to receive the quarterly clinic newsletter with health info, recipes, and updates: **YES!** No

May we leave tests results on your voicemail? **Y** **N** Preferred Phone:(circle one) Home Work Cell

Emergency Contact: _____Relationship:_____Phone:_____

Preferred Pharmacy: _____Address: _____Phone:_____

Legal Guardian (minors only):_____Phone:_____

How did you hear about us? _____

ALLERGIES: _____

Please list other healthcare practitioners you are presently seeing: _____

_____

Briefly describe your primary health concern that has brought you here today: _____

_____

_____

Please list any medications or supplements you take and their dosages: _____

_____

_____

Insurance Information:

Company/Plan name: _____ Phone:_____

Claims Address: _____

City, State, Zip: _____

Subscribers Name and Date of Birth: _____

Relationship to patient: Self Spouse Parent Other: _____

ID# on card: _____ Group #: _____

Is this visit injury related? Y N Work related? Y N Auto Accident: Y N Date of Injury:_____

Secondary and/or Tertiary Insurance: _____

Review of Symptoms

Check if you have had any of the following in the last six months

General

- Fatigue
- Physical Pain
- Libido change
- Fevers
- Allergies

Neurological

- Weakness
- Tremor
- Depression
- Crying spells
- Excess worry
- Phobia/Fears
- Panic Attacks
- Anxiety
- Irritability
- Hallucinations
- Seizures
- Easy distraction
- Balance issues
- Fainting
- Dizzy on standing
- Poor concentration
- Poor memory
- Confusion
- Speech problem
- Change in Taste
- Change in Smell
- Change in Vision
- Hearing loss
- Ears ringing
- Headaches
- Numbness

Skin

- Rash
- Eczema
- Psoriasis
- Dry Skin
- Easy Bruising
- Hives
- Slow healing
- Varicose veins
- Excessive sweating

Musculoskeletal

- Soreness
- Muscle cramps
- Weakness
- Muscle jerks
- Arthritis
- Joint pain
- Back pain

Urinary System

- Urinating often
- Burning urine
- Hesitation on starting urination
- Obstructed flow
- Loss of urine with cough/sneeze
- infection
- Bed wetting
- Difficulty urinating
- Wake to urinate
- Urgent urination

Gastrointestinal

- Canker sores
- Swollen tongue
- Heartburn
- Indigestion
- Ulcer
- Nausea
- Vomiting
- Intestinal gas
- Bloating
- Constipation
- Diarrhea
- Hemorrhoids
- Loss of Appetite
- Abdominal pain
- Gas pains

Cardiovascular

- Chest pain on exertion
- Leg pain on exertion
- Swollen extremities
- Cold hands/feet
- Irregular pulse
- Rapid heart rate
- Slow pulse

Respiratory

- Congestion
- Sinusitis
- Sneezing
- Itchy eyes
- Watery eyes
- Dry eyes
- Ear infections
- Sore throat
- Drainage into throat
- Hoarseness
- Swollen lymph nodes
- Shortness of breath
- Asthma
- Wheezing
- Tight chest
- Chest pain
- Cough
- Bronchitis
- Pneumonia

Sleep

- Trouble falling asleep
- Trouble staying asleep
- Hard to wake up
- Trouble staying awake
- Usually tired
- Wake to urinate

Sexual Health

- STD
- Pain with vaginal sex
- Pain with anal sex
- Orgasm difficulties
- Erectile dysfunction
- Ejaculation difficulties

Patient Name:

_____

Gynecologic

- Vaginal burning
- Vaginal itching
- Vaginal discharge
- Vaginal infection
- Irregular periods
- Menstrual cramps
- PMS Symptoms
  - Headaches
  - Bloating
  - Constipation
  - Weight gain
  - Irritability
  - Depression
  - Fatigue
  - Food craving
- Hot flashes
- Vaginal dryness
- Abnormal PAP

Substance Use Problems/Out of Control Behaviors:

- Alcohol
- Cigarettes
- Caffeine
- Marijuana
- Prescription drugs
- Work
- Sex
- Eating
- Other _____

Others

_____

_____

_____

_____

_____

_____

Health History

Family History (fill in health information about your family)

Relation	Age	Health	Age of	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma	
	Allergies	
	Cancer (type)	
	Chemical	
	Diabetes	
	Heart Disease	
	Stroke	
	High Blood	
	Kidney DIsease	
	Obesity	
	Tuberculosis	
	Vascular Disease	
	Other	

Hospitalizations

Year	Hospital	Reason and outcome

Pregnancy History

Year	Outcome	

Have you ever had a blood transfusion? Yes No
If yes, please give date(s)

Health Habits (Check and list how much you use)

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	
	Other	

Serious Illness/Injuries

Date	Incident	Outcome

Allergies (Medications or Substances)

Pharmacy (Name and number)

Do you have a will or durable power of attorney for your medical care in the event of an emergency? Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any member of the University Health Clinic staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient name: _____ Date _____

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Financial Policies

Payment:

- All fees are due at the time of service. However, if you have a health insurance plan we are contracted with and provide us the necessary information, we will bill your insurance carrier. All co-payments will be due at the time of service and may be paid by cash, check, or credit card.
- Remember, while many insurance carriers cover naturopathic physicians, acupuncturists, and chiropractors, each company and each plan within that company differ. Our staff will assist you, as a courtesy, but you are responsible for knowing your benefits, deductibles, and exclusions (i.e. we will only charge the insurance the "allowable amount" and not bill you for any differences).
- If you currently do not have insurance coverage, you will be responsible to pay at the time of service and we will extend a 10% discounted rate.

Appointment Changes and Cancellations:

- Due to the high demand for appointments, we require at least 24 hours notice for the changing or cancellation of appointments. A 'no show' or cancellation without 24 hours notice will result in a $75 charge.

Non-Covered Services:

- Non-covered services are those visits, procedures, diagnostic codes, telephone consults, etc. that are not covered by your insurance. We are allowed to bill you for any denied charges or non-covered services.

Fees:

- Lab charges: Meridian Medicine charges $20 for all blood draws as a doctor performs this procedure, but we do not want to bill you for an office visit that leaves you with a co-pay.
- Copy fees: No fees will be charged if medical records are sent directly to another healthcare provider. However, we may charge patients, law firms, etc. for copies as the law allows.
- Accounts delinquent over 120 days will be turned over for collection charged the full fee, plus reasonable collection and attorney fees.
- Telephone consults: Anything beyond a brief (10 min.) phone call involving a practitioner will be billed to you at regular office visit rates. This includes non-urgent phone calls after hours.
- NSF (Non-Sufficient Funds) will be charged a $35 fee.
- Paging Fee - $50.00
- Online Medical Management Fee - $50.00

I have read, and understood, that I may be billed for the above services. I have been offered a copy of this information and agree to abide by the financial policy of Meridian Medicine.

Print Name_____ Patient Signature_____

Date