

The University Health Clinic

5312 Roosevelt Way NE
Seattle, WA 98105
Phone 206-525-8015 Fax 206-525-8014

Patient Information:

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

Other/Maiden Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer/School: _____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Yes! I would like to receive the clinic quarterly newsletter. No, I would not like to receive the newsletter.

May we leave tests results on your voicemail? Yes No Best number to call: _____

Legal Guardian Name (minors only): _____

Emergency Contact/Relationship: _____ Phone number: _____

Do you have any Special Needs? _____

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 Insurance? If Yes, then please fill out top portion of other side of this form.

Health History

Family History (fill in health information about your family)						
Relation	Age	Health	Age of death	Cause of death	Check if, your blood relatives had any of the following:	
Father						Disease
Mother						Relationship to you
Brothers						Arthritis, Gout
						Asthma
						Allergies
						Cancer (type)
						Chemical dependency
						Diabetes
Sisters						Heart Disease
						Stroke
						High Blood Pressure
						Kidney Disease
						Obesity
						Tuberculosis
						Vascular Disease
						Other
Hospitalizations				Pregnancy History		
Year	Hospital	Reason and Outcome		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)		
Serious Illness/Injuries					Caffeine	
Date	Incident	Outcome			Tobacco	
					Drugs	
					Alcohol	
					Other	
					Other	
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.

Initial _____ Date _____

Review of Systems

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

General

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

Neurological

- Weakness
- Tremor
- Depression
- Low endurance
- Crying spells
- Agitation
- Excess worry
- Phobia/Fears
- Panic Attacks
- Anxiety
- Suspicious
- Irritability
- Hallucinations
- Seizures
- Feeling shaky
- Hyperactive
- Easy distraction
- Balance issues
- Fainting
- Dizzy on standing
- Blackouts
- Poor concentration
- Poor memory
- Trouble thinking
- Indecisive
- Confusion
- Speech problem
- Change in Taste
- Change in Smell
- Blurry Vision
- Change in Vision
- Hearing loss
- Ears ringing
- Headache, tension
- Headache, migraine

Skin

- Numbness
- Rash
- Eczema
- Psoriasis
- Dry Skin
- Easy Bruising
- Hives
- Slow healing
- Varicose veins
- Excessive sweating
- Sweaty palms/feet

Musculoskeletal

- Soreness
- Muscle cramps
- Weakness
- Muscle jerks
- Arthritis
- Joint pain
- Back pain
- Limited range of motion

Urinary System

- Urinating often
- Burning urine
- Hesitation on starting urination
- Obstructed flow
- Loss of urine with cough/sneeze
- infection
- Bed wetting

Gastrointestinal

- Mouth ulcers
- Canker sores
- Swollen tongue
- Heartburn
- Indigestion
- Ulcer
- Nausea
- Vomiting
- Intestinal gas
- Bloating
- Constipation
- Diarrhea
- Hemorrhoids

Cardiovascular

- Loss of Appetite
- Abdominal pain
- Gas pains
- 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
- Red 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
- Vaginal burning

Female

- Vaginal itching
- Discomfort
- Discharge
- Infection
- Hair growth on face
- Irregular periods
- Menstrual cramps
- PMS Symptoms
- Headaches
- Bloating
- Constipation
- Weight gain
- Irritability
- Depression
- Fatigue
- Food craving
- Hot flashes
- Trouble sleeping
- Vaginal dryness

Male

- Difficulty urinating
- Wake to urinate
- Urgent urination
- Sexual dysfunction

Addictions

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

Others

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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 naturopathic physicians and acupuncturists are covered by many insurance carriers, 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. mental health, or other non-covered diagnoses). We will only charge the insurance the “allowable amount” and not bill you for any differences.
- If you are unsure of your coverage, you may opt to pay for your visit in full, at the time of service, for a discounted rate (20%) via cash, check or credit card. We will then bill your insurance carrier for that rate and, if paid, will apply the amount to any outstanding balances or refund you, whichever is your preference.
- If you currently do not have insurance coverage, you must pay at the time of service in order to receive a 20% 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 \$50 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. Some other categories of non-covered services are:
 - Wellness visits and non-curative (palliative) treatments
 - Counseling
 - Functional lab tests-considered ‘investigational’ or ‘experimental’
 - If you have any questions regarding these types of visits please speak to the receptionist.

Fees:

- Lab charges: The University Health Clinic charges \$10 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.
- To provide you the best care possible, we will not provide ‘email healthcare’.

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 the University Health Clinic.

Print Name _____

Patient Signature _____

Date _____