Date of First Office Call: _____

WELCOME

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

PATIENT INFORMATION

Last Name		Date of Birth	
First Name		Social Security #	
Middle Initial		Sex	
Street Address		Name of Guardian(s)	
City, State, Zip			
Email Address		Name of Sibling(s)	
Home Phone			
Work Phone		Additional Family	
Cell Phone		Contact Information	
Secure Message	☐Home ☐Work ☐Cell		

RESPONSIBLE PARTY

Person Responsible for Account _____

Responsible Party's Birth Date _____

Responsible Party's Address _____

Resp. Party's Phone # Resp. Party's Social Sec.#

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?

Please give us information to thank your referral source:

- ☐ Physician:
- ☐ Patient:
- ☐ ECN Website
- ☐ Other

EMERGENCY CONTACT

Name _____

Phone Number _____

Relation

Patient Name: _____ Date of First Office Call: _____

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 #: _____

1. Are you currently under medical treatment? Yes ☐ No ☐

Please describe: _____

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

Please describe: _____

3. Women only

	Yes	No
Do you have regular periods?	☐	☐
Are you taking birth control?	☐	☐
Have you ever been pregnant?	☐	☐

Number of Pregnancies:_____

4. Are you currently taking any medications? Yes ☐ No ☐

Please describe: _____

5. Have you ever had a reaction to?:

	Yes	No
Local anesthetics (eg. Novocaine).....	☐	☐
Penicillin or other antibiotics.....	☐	☐
Sulfa Drugs.....	☐	☐
Sedatives.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
Barbiturates (sleeping pills)	☐	☐
Other.....	☐	☐

Please Explain:

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

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 dependents. 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_____