

Patient Name:

Today's date:

First Middle Last

Address:

Number Street Apt number City State Zip

Date of birth: _____ **Age:** _____ **Gender:** () F () M **Ht:** _____ **Wt:** _____

SSN: _____ **Home phone:** _____ OK to leave message? Y N

Employer: _____ **Work phone:** _____ OK to leave message? Y N

Referred by: _____ **Cell phone:** _____ OK to leave message? Y N

Email: _____ OK to leave message? Y N

Name of spouse/partner: _____ **Date of birth:** _____

Emergency contact: _____ **Relationship:** _____ **Phone:** _____

INSURANCE

Insurance company: _____ **Phone:** _____

Subscriber Name: _____ **Date of birth:** _____

Subscriber's SSN: _____

Relationship to you: () Self () Spouse () Child () Other

ID number as shown on card: _____ **Group number:** _____

Employer of subscriber: _____

AUTO / L & I (if applicable)

Is this visit injury related? () Y () N **Work related?** () Y () N **Auto accident?** () Y () N **State:** _____

Insurance company: _____ **Phone:** _____

Claim address: _____

Subscriber's name: _____ **Date of birth:** _____

Relationship to you: () self () spouse () dependent () other

ID / Claim # : _____ **Policy #:** _____

Employer if applicable: _____ **Effective / Date of Injury:** _____

I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

I am financially responsible for all charges. I agree to pay for all charges not covered by my health insurance. If I fail to cancel an appointment at least 24-business-hours in advance, I agree to pay a fee of up to **\$150.00 (late cancel fee)**. I agree to **pay copay and coinsurance at time of service to avoid \$10 billing fee**. I agree to pay a fee of **\$35.00 for each returned check**.

Signature: _____ **Date:** _____

HEALTH INFORMATION---confidential

Present Health Concerns in order of importance.

How Long?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Chronic health problems you have had for years not listed above

How long?

Still active?

- 1) _____ Yes / No
- 2) _____ Yes / No
- 3) _____ Yes / No
- 4) _____ Yes / No

Family history

Father

Mother

Aunt/uncle

Grandparents

Siblings

Heart disease/cholesterol					
High blood pressure					
Stroke					
Obesity					
Cancer (type)					
Cancer (type)					
Cancer (type)					
Diabetes					
Thyroid disease					
Osteoporosis					
Early menopause					
Breast, uterine, ovarian disorder					
Mental illness					
Allergy, asthma, hay fever					
Blood disorder, anemia					
Arthritis, muscle pain					
Other					
Other					

Surgeries, hospitalizations, major injuries, and serious illnesses:

Year

Outcome

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Allergies: Please list all **food, environmental,** and/or **drug** allergies.

Habits:

Smoking: No / Yes ___ pack a day for ___ years Recreational drug: _____

Alcohol: No / Yes ___ glasses of wine, beer, mixed drink, _____ per day / week/ month / year

Exercise: No / Yes Aerobic _____ Weight _____

Coffee: ___ cups /day Tea: ___ cups /day Cola/pop: ___ / day Aspirin/Tylenol/Analgesic: _____

Stress level (10 being highest): 1 2 3 4 5 6 7 8 9 10

Digestion: Heart burn Stomach upset Bloating Burping Gas Nausea

Rate your meal average per week (1 being poor, 5 being excellent/healthiest): 1 2 3 4 5

Sweets / chocolate intake average per week (1 being negligible, 5 being large amount): 1 2 3 4 5

Medications: Prescription and Over-the-counter. Please list medications that you are taking now.

Name of drugs/ medicine	Reason for taking	Doses: milligrams or # of capsules	How many times per day or week	How long have been taking ?

Vitamins, herbs, and supplements you are taking **now**

Name of herbs	Reason for taking	Doses	How many times per day or week	How long have been taking ?

Review of Health: please circle any of the following problems not mentioned before

General: recent weight gain / loss, fevers, night sweats, fatigue

Skin: itching, rash, infection, eczema, psoriasis, lumps, hair loss

Eye/ear/nose/throat: hearing, vision, dental problem, sinus infection, colds, swallowing problem, swollen glands, allergies, sore throat, Strep, pain, discharge, sensitive to pollen / dust / mold

Head / Neck: migraine, tension headache, dizzy, fainting

Heart: Chest pain, palpitations, high blood pressure, irregular heart beat, murmur, swollen legs

Lung: cough, shortness of breath, asthma, frequent bronchitis, pneumonia

Digestive: indigestion, food stays in stomach / slow emptying, bad breath, constipation, diarrhea, irritable bowel, mucus or blood in stool, hemorrhoid, heart burn / acid reflux, ulcer, lump in throat, bloating, gas, nausea, vomiting

Liver / gall bladder: hepatitis B or C, fatty liver, gall stone, gall bladder removed

Genital / Urinary: frequent or painful urination, burning, urgency, blood in urine, leakage / can't get to bathroom on time, kidney stone, bladder or kidney infection, sexually transmitted disease, Herpes

Male: BPH, prostate infection, difficult to maintain erection, use medication

Female / reproductive: PMS, ___ day cycle, period lasting ___ days, light / normal / heavy bleeding, spotting between cycle, irregular cycle, birth control pills / ring / Depo provera / _____, fibrocystic breasts, breast lump / cyst, fibroids, ovarian cyst, pregnancy ___ times, birth ___ times, termination ___ times, miscarriage ___ times

Peri- or Post-menopause: on HRT, hot flushes, sleep disturbance, mood swings, shorter cycle between periods, night sweats, spotting, bursitis / tendonitis, osteoporosis, osteopenia

Hormones / endocrine: hypothyroid, hyperthyroid, diabetes

Joints / bone / muscles: pain in neck, back, low back, shoulder, elbow, wrist/hand, hip, knee, ankle, or foot. Muscle pain all over

Neurologic: numbness, tingling, pain, loss of sensation, decreased / loss of arm or leg function

Bleeding, bruising, anemia

Psychological: feeling sad, crying, hopeless, insomnia, poor appetite, weight change, tired all the time, not interested in activities/ socializing, irritable, poor concentration, anger, lack of libido, anxiety, hard to swallow

Major life changes: marriage, divorce, move, job, death of _____

Anything else we should know about you? _____

Mutual Understanding, Informed Consent for Treatment, and Financial Policy Agreement

Confidentiality: Information provided during the visit is confidential. No information will be released to others unless you direct us to do so or the law compels us to do so.

If you have a serious health problem that requires immediate attention, please call 911.

Treatments with other practitioners are not necessarily to be discontinued. It is your responsibility to inform Dr. Yu if you are being treated by other healthcare providers. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.

No guarantees: Although your unique health status will be researched and treatment customized, no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s). We invite you to ask any questions and actively take part in your health care.

Physical examination, naturopathic treatment, and massage do involve physical contact, which may be uncomfortable for some persons. If you are uncomfortable or unfamiliar with naturopathic treatments, please let Dr. Yu know so that we can assist you, explain it to you, and/or modify treatments.

Potential risks: while naturopathic treatments are remarkably safe, there may be potential risks associated with your care. Please be advised of the following risks and ask us any questions you may have: allergic reaction to herbs, supplements, other treatments, or supplies; post-treatment soreness and stiffness in skin, joints, muscles or other soft tissues; and other unforeseen possible injuries. We take every precaution to prevent injury. Please ask any questions or concerns you have before the start of the treatments.

Notice to Pregnant Women: please let Dr. Yu know if you know or suspect the pregnancy as some therapies can present a risk to the pregnancy.

Cancellation Policy: If you cannot keep the appointment, **PLEASE CALL 24-BUSINESS_HOURS IN ADVANCE at 425-644-6048. We do charge \$75 to \$150 for a missed appointment or cancellation less than 24-hour notice.**

Insurance: You are responsible to know and inform us of your insurance eligibility and coverage. Some insurance do not cover naturopathic medical visits. It is your responsibility to verify if your insurance covers naturopathic visits. You are ultimately responsible for all charges regardless of insurance coverage.

Financial Information: Dr. Yu will bill your insurance if you request. Any remaining balance must be paid immediately. The unpaid balance after 30 days will accrue 1.5% (of the balance) finance charge per month. Balance not paid in 120 days will be turned over to **Collection**. We charge **\$35 for each returned check** (RCW 62A.3 515520). Copays and coinsurance are due at time of service to avoid \$10 billing fee. We charge **\$10 billing fee** for each bill or invoice.

The information I provided on this registration forms is complete and accurate. I understand risks and my responsibilities. I will not hold physicians and staff at this clinic responsible for any errors or omissions I may have made in completing the registration forms.

I understand and accept the terms of the above described cancellation, phone consultation, insurance, and financial policies. I am individually responsible and agree to pay for all charges.

Signature of patient or guardian: _____ **Date:** _____