

Registration
Que Areste N. D., 1605 12th Ave., Suite 16, Seattle, WA 98122
(206) 328-2926

Please Print		Date
Patient Name (Last, First Middle)		Previous Name
Street Address		City, State, Zip Code
Home Telephone ()	Mobil Phone ()	Fax ()
Email address:		Web Address:
Date of birth:	Sex: Male Female	Employer
Social Security Number ____ / ____ / ____	Marital Status: Single Married Widowed Divorced Other	Employer Address
Spouse or Significant Other Name (Last, Middle, First)		Work Phone () _____
Address (If different than patient) Street: _____		Home Phone () _____
City, State, Zip _____		Work Phone () _____
Emergency Contact Name (Person not living with you) _____		Relationship: _____ Telephone: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Que Areste N. D., Que Areste on my behalf for unpaid services rendered by Que Areste, N.D., Que Areste Clinic physicians. I authorize the release of medical information to the health plan indicated as requested by the health plan to determine the payment of medical benefits.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: H) _____ Phone: W) _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City, ST, Zip: _____

Dates and Type of information to disclose:

- 2 years prior from last date seen
 Dates Other: _____
 Specific Information Requested: _____

The purpose of disclosure is:

- Change of Insurance or Physician
 Continuation of Care (e.g., VA Med Ctr)
 Referral
 Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____
Address: _____
City, State, Zip: _____
Fax: _____ Phone: _____

- Please mail records.
 Please fax records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date _____

Printed name of Authorized Representative

Relationship / Capacity to patient

Address and telephone number of authorized representative

Private Health Insurance Information Form

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home # (____) _____ Work # (____) _____ Date of Birth _____
SS# _____ Date of Injury _____ Referring Doctor _____

**In Order To Bill Your Private Health Co. Please Ask For An Insurance Verification Form.
And Please Complete The Following:**

<u>Insurance Co. Name</u> _____	<u>Phone #</u> (____) _____	
Address _____	City _____ State _____ Zip _____	
Policy # _____	ID _____ # _____	Group/Plan # _____
Plan or Program Name _____	Name of Insured _____	
Insured's Address _____	City _____ State _____ Zip _____	
Insured's Phone (____) _____	Insured's SS# _____	Insured's Date of Birth _____
Your Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child		
Insured's Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	<u>Insured's Employer or School</u> _____	

Please read and sign below:

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature: _____
(Patient / Parent / Guardian)

Date: _____

MEDICAL HISTORY QUESTIONNAIRE

NAME _____ AGE _____ BIRTHDATE _____ DATE TODAY _____

PAST HISTORY CHECK ANY OF THE FOLLOWING YOU HAVE HAD. IF IN DOUBT, PUT A QUESTION MARK.

- MUMPS
 - MEASLES
 - GERMAN MEASLES
 - CHICKEN POX
 - WHOOPING COUGH
 - POLIO
 - TYPHOID
 - RHEUMATIC FEVER
 - HEART TROUBLE
 - HEART MURMUR
 - HIGH BLOOD PRESSURE
 - GOUT
 - ARTHRITIS
 - PNEUMONIA
 - TB
 - ASTHMA
 - HAY FEVER
 - ECZEMA
 - ALLERGY OR UNDESIRABLE REACTION
TO ANY MEDICINES OR INJECTIONS
 - OTHER ALLERGIES

- KIDNEY STONES
 - KIDNEY INFECTION
 - BLADDER INFECTION
 - LIVER DISEASE
 - HEPATITIS
 - GALLBLADDER DISEASE
 - JAUNDICE (YELLOW EYES OR SKIN)
 - STOMACH ULCER
 - DUODENAL ULCER
 - EPILEPSY (FITS, BLACKOUTS)
 - GLAUCOMA
 - DIABETES
 - THYROID TROUBLE
 - ANEMIA
 - ABNORMAL BLEEDING TENDENCY
 - PHLEBITIS (CLOTS IN VEINS)
 - FATIGUE

YEAR	FRACTURES OR SERIOUS INJURIES
YEAR	OPERATIONS

YEAR	OTHER UNUSUAL OR SERIOUS ILLNESS
YEAR	OTHER HOSPITALIZATIONS

FAMILY HISTORY	NAME	ILLNESSES	AGE, IF LIVING	AGE, IF DECEASED	CAUSE OF DEATH, IF DECEASED
FATHER					
MOTHER					
BROTHERS					
SISTERS					
HUSBAND OR WIFE					
CHILDREN					

CIRCLE IF ANYONE IN YOUR FAMILY HAS HAD THE FOLLOWING: RHEUMATIC FEVER, EPILEPSY, TB, DIABETES, CANCER, GLAUCOMA,
GOUT, HIGH BLOOD PRESSURE, PEPTIC ULCER, ASTHMA, ALLERGIES. NONE OF THESE.

None of these.

HABITS INDICATE YOUR USUAL AMOUNT OF:

COFFEE _____ **DECAF COFFEE** _____ **ALCOHOL** _____

TEA _____ - COCA _____ SLEEP _____

SMOKING **MILK** **EXERCISE**

DO YOU FOLLOW A SPECIAL DIET OR EATING PATTERN DUE TO MEDICAL PROBLEMS?

HOW OFTEN DO YOU WEAR YOUR SEAT BELT?

RECENT ACQUISITION

PRIOR ORGANIZATIONS

NAME OF GUEST ATTENDS _____

LIST ALL VITAMINS, LAXATIVES AND MEDICINES YOU USE, AND AMOUNTS USED

Name _____ Birthdate _____ Today's date _____

Review of Systems

General

Weight	_____
Weight 1 year ago	_____
Maximum weight	_____
Maximum when?	_____
Height	_____
Date of last Physical	_____
Fatigue	Y P N
Night Sweats	Y P N

Skin

Rashes	Y P N
Inflammation	Y P N
Infection	Y P N
Growthths	Y P N
Change in hair/nails	Y P N

Head

Headache	Y P N
Head Injury	Y P N

Eyes

Impaired vision	Y P N
Eye Pain	Y P N
Tearing or dryness	Y P N
Double Vision	Y P N

Ears

Impaired hearing	Y P N
Ringing	Y P N
Earache/itch	Y P N
Dizziness	Y P N

Nose and Sinuses

Frequent Colds	Y P N
Nose bleeds	Y P N
Stuffiness	Y P N
Sinus problems	Y P N
Post nasal drip	Y P N

Mouth & Throat

Frequent sore throat	Y P N
Sore tongue	Y P N
Sores-mouth/lips	Y P N
Gum problems	Y P N
Hoarseness	Y P N
Dental Problems	Y P N

Neck

Swollen glands	Y P N
Pain or stiffness	Y P N

Blood

Anemia	Y P N
Easy bleeding or bruising	Y P N

Respiratory

Cough	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
" While laying down	Y	P	N
" At night	Y	P	N
Positive TB test ever?	Y	P	N

Circulation

Deep leg pain	Y	P	N
Cold hands & feet	Y	P	N
Varicose veins	Y	P	N

Neurologic

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Loss of memory	Y	P	N

Endocrine

Thyroid problem	Y	P	N
Heat /cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Easy weight gain	Y	P	N

Breasts

Regular self exams	Y	P	N
Lumps	Y	P	N
Pain or tenderness	Y	P	N
Nipple discharge	Y	P	N

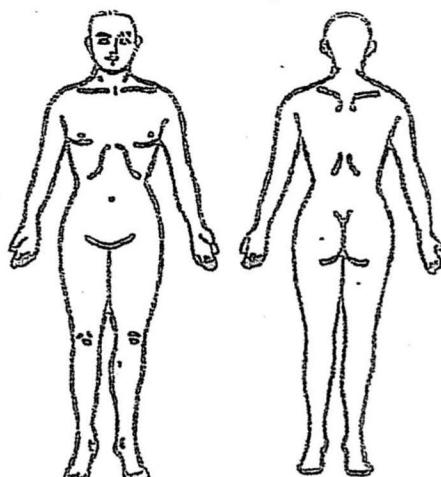
Emotional

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety or nervousness	Y	P	N
Tension	Y	P	N
Weakness	Y	P	N

Musculoskeletal

Joint pain or stiffness	Y	P	N
Broken bones	Y	P	N
Muscle spasms or cramps	Y	P	N
Weakness	Y	P	N

Indicate on diagram any problem areas:



Name _____ Birthdate _____ Today's date _____

Review of Systems

Female Reproduction

Age menses began _____
of days last menstrual flow _____
Length of complete cycle _____
Bleeding between periods Y P N
Regular menstrual cycles Y P N
Pain during intercourse Y P N
Cramps Y P N
Abnormal vaginal discharge Y P N
Excessive flow Y P N
PMS Y P N
Date of last PAP _____
Abnormal PAP Y P N
Date of last period _____
pregnancies _____
live births _____
miscarriages _____
abortions _____
Birth Control Y P N
What type _____
Difficulty conceiving Y P N
Menopausal Symptoms Y P N
Are you sexually active? Y P N
Sexual difficulties Y P N
Venereal disease Y P N

Male Reproduction

Hernias Y P N
Testicular masses Y P N
Are you sexually active? Y P N
Sexual difficulties Y P N
Prostate problems Y P N
Venereal disease Y P N
Discharge or sores Y P N
Difficulty starting or stopping urination Y P N
Birth Control Y P N
What type _____