Patient Name: _______________________________ Date: ___________________

This is to confirm my appointment on: _________________________ at: __________________

Physician: ____________________________

Welcome to the Tahoma Clinic! We are honored that you have chosen us to help in your search for optimum health. This is your New Patient Information Packet. Please read, fill out and sign the attached forms and bring them with you to your appointment unless you have been instructed to send them in prior to your appointment.

If you wish to cancel or reschedule your appointment, please notify our office 48 hours or more before your appointment. If you choose to cancel your appointment entirely, we will collect a $50.00 Charge.

It is our office policy to confirm appointments by phone two days before your appointment. If you have an answering machine or voice mail, a message will be left. In some cases, the doctor may request fasting lab tests, so we ask that you have no food 8 hours prior to your appointment, if your appointment is before 1:00pm. If your appointment is scheduled after 1:00 and your doctor determines a fasting test is necessary for you, the test will need to be rescheduled at a later date. Please do not fast, if you have diabetes, hypoglycemia or simply cannot do so. If you have any questions please call our office at (206) 812-9988. We look forward to meeting you!

Many of our patients are sensitive to environmental substances, therefore we ask all patients to refrain from wearing scented hairsprays, colognes, perfumes, aftershaves, etc. on the days you are here.
**CASE HISTORY**

Today's Date _____ / _____ / ______

Name_________________________________  DOB _____/_____/______ Male □ Female □
(PRT) Last First MI

Address______________________________________________________________
Street City State Zip/Postal code

Primary Contact ( ) ________________________________________________

Is it okay to leave a DETAILED message at this number?   Yes □   No □

Work ( ) __________________________ Email ________________________________

Fax ( ) ______________________________

Employed by_________________________ Occupation __________________________

Referred by (Please Circle):

1. Internet
2. Friends and Family Members
3. Yellow Pages
4. Drive by
5. Other_________________________

Emergency contact __________________________________________________
Name Telephone Address

Primary Care Physician _________________________________________________
Name Telephone Address

List the main problems that you are having, or reason for this appointment:

1_____________________________________________________________
2_____________________________________________________________
3_____________________________________________________________

Please attach additional page if necessary
Are you of African or Ashkenazi Jewish ancestry? (This is an important factor in certain medical conditions and can also affect the choice of certain treatments.) No_____; Yes_____: African / Ashkenazi Jewish (please circle one)

**Past Medical History:**

Major Illnesses:

______________________________________________________________________________
______________________________________________________________________________

Accidents or major trauma (Scars – Please give location)

______________________________________________________________________________
______________________________________________________________________________

Hospitalizations/Surgeries/Emergency visits – please give month/year if possible:

______________________________________________________________________________
______________________________________________________________________________

Dental Procedures (root canals, etc.)

______________________________________________________________________________
______________________________________________________________________________

Current Prescription Medications (names and doses)

______________________________________________________________________________
______________________________________________________________________________

Allergies to medications

______________________________________________________________________________
______________________________________________________________________________

Sensitivities: Foods, environmental, etc.–Ever tested? Copies of reports?

______________________________________________________________________________
______________________________________________________________________________

Occupational Exposures:
Vaccinations:

( ) DPT (Diphtheria, Pertussis, Tetanus) Year(s)_______________________________
( ) Booster (Usually DT) Year(s)_______________________________
( ) Polio injection ( ) Polio oral Year(s)_______________________________
( ) MMR (Measles, Mumps, Rubella) Year(s)_______________________________
( ) HBV (Hepatitis B Vaccine) Year(s)_______________________________
( ) Other (Flu shots, etc.) Year(s)_______________________________

Women:
Last Pap_________________First day of last menstrual period_________________
Marital history: Years married_________# of children_________Ages________
No. of Pregnancies_________Deliveries_________complications________
Last Mammogram______________ Last Thermogram______________

Men:
Last prostate exam__________ Last PSA result________________Date________

Lifestyle factors (Please fill in the approximate amounts):

<table>
<thead>
<tr>
<th>Coffee</th>
<th>Occasionally</th>
<th>Weekly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tobacco</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Alcohol</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Exercise Activities

<table>
<thead>
<tr>
<th>Swim</th>
<th>Never</th>
<th>Minutes</th>
<th>Hours</th>
<th>Weekly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td></td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Run</td>
<td>□</td>
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<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Walk</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Dance</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bike</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Garden</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Golf</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tennis</td>
<td>□</td>
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<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ski</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Weights</td>
<td>□</td>
<td></td>
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<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Other____________________________________________________________________
IN ORDER TO HELP FACILITATE THE VISIT BETWEEN YOU AND YOUR PHYSICIAN, PLEASE FILL IN THIS FORM WITH ANY VITAMIN, MINERAL, AMINO ACID, OTHER SUPPLEMENTS OR MEDICATION THAT YOU MAY BE TAKING.

NAME:_____________________________________ DATE:_______________

ADDRESS:__________________________________________________________________

DOCTOR:__________________________________________________________________

<table>
<thead>
<tr>
<th>SUPPLEMENTS</th>
<th>MANUFACTURER</th>
<th>FORM</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
<th>REASON FOR TAKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>VITAMIN C</td>
<td>BRONSON</td>
<td>TABLET</td>
<td>500 MG</td>
<td>2 PER DAY</td>
<td>IMMUNE SUPPORT</td>
</tr>
</tbody>
</table>

COMMENTS:

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
Diet Log
Please write down what you eat and drink for a week! This includes juice, coffee, alcohol. If you're attempting to follow any particular diet, please indicate that in the space below the table, IE Swank diet, Atkins.

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Snack</td>
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</tr>
<tr>
<td>Lunch</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Family Medical History

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

Father:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

Brothers and Sisters:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

Mother’s Parents:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

Father’s Parents:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

Children:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

Possible Illnesses In Alphabetical Order:

- Allergies
- Asthma
- Bleeding Tendency
- Cancer, Type
- Crohn’s Disease
- Diabetes-Age at Onset
- Drug Abuse
- Epilepsy
- Gall Bladder
- Glaucoma
- Heart Disease-Type
- Hearing Loss
- Hypoglycemia
- Kidney Disease
- Liver Disease-Type
- Lupus
- Mental Illness-Type
- Multiple Sclerosis
- Rheumatoid Arthritis
- Thyroid Disease
- Tuberculosis
- Skin Disease-Type
- Other Conditions
We at the Tahoma Clinic are here to help you take care of your health in the best way that we know how. We realize you came in about health and not finances. The following is to assist you in understanding the Tahoma Clinic financial policies.

**Payment Requirements:** Appointments must be paid for at time of service. We accept Visa, MasterCard, Discover, American Express, Cash, or Traveler’s checks. Please contact bookkeeping for more details. Any services rendered at the Tahoma Clinic Dispensary and Meridian Valley Lab must be paid directly to them.

**Fee Structure:** The Tahoma Clinic is not a membership organization. We do not charge a large up-front fee to cover membership and potential future expenses. Charges are based on actual time and services used. This means that each appointment and test, including check backs required to review lab work, is billed separately. This way you do not pay for services that you do not use.

***Phone appointments are charged the same as in-person appointments.***

**Appointments:** We require **48 hours notice** if you need to change or cancel your appointment. You will be charged a fee of $50 of any missed appointment, or if the 48 hour advance cancellation policy was not met.

**Records:** We keep a record of your health care. Tahoma Clinic patients are given their patient records upon completion of their doctor visit. If for some reason your records become unavailable to you, we will furnish you with a copy of your medical records upon your signing an authorization form and returning it to our records department. Please allow up to 10 working days for us to process the request. A small fee will be charged for this service. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to.

**Insurance and Medicare:** Tahoma Clinic does not bill insurance companies. Our doctors are not preferred providers for any insurance company. You may submit your paid invoice to your insurance for reimbursement. **We are not a Medicare provider.** Medicare will not reimburse you for services rendered at the Tahoma Clinic and you should not seek reimbursement from Medicare. We do have staff available to answer any of your insurance questions.

I understand that I will have asked a practitioner of the Tahoma Clinic for help and that he/she will help to the best of his/her ability.

*I have read and understand the above statements.*

________________________________________  __________________________________________  __________/______/______
Print Full Name  Signature (signed by guardian if under-age)  Today’s Date
Release of Information

FRIENDS AND FAMILY AUTHORIZATION

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will, on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that some information is considered “sensitive”. I understand that I must check the specific boxes in order for my provider or his/her designee to release any “sensitive” information.

☐ Mental Health/Psychiatric Disorders (including depression)*
☐ Chemical Dependency (drug and/or alcohol abuse/treatment)*
☐ HIV/AIDS Virus*
☐ Sexually Transmitted Diseases*

* A minor patient’s signature is required in order to release information concerning care for: 1) Conditions relating the minor’s sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above); 2) Alcohol and/or drug abuse (age 13 and above); and 3) Mental health conditions (age 13 and above).

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date as I recognize that relationships and friendships may change over time.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>________________________</td>
</tr>
<tr>
<td>2.</td>
<td>________________________</td>
</tr>
<tr>
<td>3.</td>
<td>________________________</td>
</tr>
</tbody>
</table>

EMERGENCY CONTACT INFORMATION

Name: ________________________________ Relationship: ________________________________

Phone Number(s): ________________________________

Patient Name: ________________________________ Date of Birth: ________________________________

Patient Signature: ________________________________ Today’s Date: ________________________________

Signature of Minor Releasing Info: ________________________________ Today’s Date: ________________________________

Parent/Legal Guardian Signature: ________________________________ Today’s Date: ________________________________