



TAHOMA CLINIC

6839 Fort Dent Way, Suite 134  
Tukwila, Washington 98188  
Phone (206) 812-9988  
Fax (206) 812-9989

**Medical Director Jonathan V. Wright, MD**

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.**

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CASE HISTORY

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_, \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female   
(PRINT) 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:**

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**Accidents or major trauma (Scars –Please give location)**

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

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**Dental Procedures (root canals, etc.)**

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**Current Prescription Medications (names and doses)**

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**Allergies to medications**

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

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**Occupational Exposures:**

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**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):**

	Never	Occasionally	Weekly	Daily
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Exercise Activities**

	Never	Minutes	Hours	Weekly	Daily
Swim	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Run	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dance	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bike	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Garden	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Golf	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Tennis	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ski	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Weights	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Other \_\_\_\_\_



# 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.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							

## Family Medical History

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

### Mother:

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### Father:

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### Brothers and Sisters:

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### Mother's Parents:

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### Father's Parents:

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### Children:

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### 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

**\*\*Very Important Information \*\***

**Please Read Carefully, Initial and Sign After Reading**

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.

\_\_\_\_\_  
INITIAL

**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.

\_\_\_\_\_  
INITIAL

**\*\*\*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.

\_\_\_\_\_  
INITIAL

**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.

\_\_\_\_\_  
INITIAL

**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.

\_\_\_\_\_  
INITIAL

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





TAHOMA CLINIC

**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.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____

**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: \_\_\_\_\_