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:_____

Thank You for your interest in Tahoma Clinic and our unique approach to health care. Enclosed is a case history form that will be evaluated by one of our physicians to determine if your health concerns can be addressed as a phone appointment. Please fill out the forms to the best of your ability and be sure that all forms are signed. The completed case history can be returned via fax at (206) 812-9989 or returned via mail.
The staff will notify you if it is appropriate to address your health condition over the phone and if so, what the estimated charge will be. Your credit card information will be collected, and you will be charged after the appointment.

Please read the following information carefully.

Disclaimer:

I have asked the Tahoma Clinic to evaluate my health condition without having physically traveled to Tahoma Clinic. I understand that the doctor will try to the best of his/her ability to provide helpful suggestions for my condition. I understand that receiving treatment long distance may not give the physician as much information as may be necessary or optimal for my treatment.
If you have any questions, please call our office at (206) 812-9988. We look forward to meeting you!

RETURNING THIS CASE HISTORY DOES NOT GUARANTEE THAT YOUR HEALTH CARE CAN BE ACCOMPLISHED OVER THE PHONE.

I have read and understand the above statements.

_____ _____ _____
Please Print Name **Signature** **Date**

_____ _____
Doctor's Signature **Date**

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CASE HISTORY

Today's Date_____

Name_____, _____ ____ Birthdate_____Male □ Female □
Last First MI

Address_____ _____ _____
Street City State/Prov. Zip/Postal code

Telephone: Home/Cell ( )_____
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 in 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):

	Never	Occasionally	Weekly	Daily
Coffee	□	□	□	□
Tobacco	□	□	□	□
Alcohol	□	□	□	□

Exercise Activities

	Never	Minutes	Hours	Weekly	Daily
Swim	□	_____	_____	□	□
Run	□	_____	_____	□	□
Walk	□	_____	_____	□	□
Dance	□	_____	_____	□	□
Bike	□	_____	_____	□	□
Garden	□	_____	_____	□	□
Golf	□	_____	_____	□	□
Tennis	□	_____	_____	□	□
Ski	□	_____	_____	□	□
Weights	□	_____	_____	□	□

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: _____

SUPPLEMENTS	MANUFACTURER	FORM	DOSAGE	FREQUENCY	REASON FOR TAKING
EXAMPLE: VITAMIN C	BRONSON	TABLET	500 MG	2 PER DAY	IMMUNE SUPPORT
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.

	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:

_____

_____

_____

_____

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

**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 Name	Signature (signed by guardian if under-age)	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): _____

□ **Home** □ **Work** □ **Mobile**

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

Signature of Minor Releasing Info:_____ **Date:** _____

Parent/Legal Guardian Signature:_____ **Date:** _____