REGISTRATION FORM

MILL CREEK FAMILY PRACTICE

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Legal Name:				Preferred Name:
Street Address / PO Box:				Marital Status:
City:	State:	Zip Code:		Employer:
Birth Date: / Age:	Sex: ☐M ☐F	Social Security no.: *(optional)*		Email Address: *(optional)*
Preferred contact method: (circle one) **CELL HOME EMAIL**	**CELL** Phone no.:	**HOME** Phone no.:	**WORK** Phone no.:	

INSURANCE INFORMATION

Please make sure the receptionist is given your insurance card and identification. Any applicable co-pays are due at time of service.

Name of Primary Insurance:		Name of Secondary Insurance: (if applicable)	
Subscriber's Name: __ Self	Subscriber's DOB:	Subscriber's Name:	Subscriber's DOB:
Copayment:	Relation to patient: (spouse, etc.)		Relation to patient: (spouse, etc.)

IF THE PATIENT IS UNDER 18, COMPLETE THIS SECTION

Parent/Guardian's Name:	Birth date:	Parent/Guardian's Name:	Birth date:
Phone no.:	Patient here? ☐YES ☐ NO	Phone no.:	Patient here? ☐YES ☐ NO

OTHER DEMOGRAPHIC INFORMATION *(we are required by law to ask the following questions)*

Preferred Language:	Race:	Ethnicity:
☐ English ☐ Other: _____ ☐ Decline to Answer	_____ Decline to answer	☐ Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Decline to answer

PREFERRED PHARMACY

Pharmacy Name:	Neighborhood / Cross Streets:	Pharmacy Phone Number:

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which I or my dependents are entitled to under my health insurance plan, as well as release any information by provider or insurance company required for the account. Release if information to include: (1) alcohol and/or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Diseases), and (4) treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions. I hereby release MCFP from all legal responsibility or liability that may arise from disclosure as provided by this paragraph. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance at 1%per month from the date of service, collection fees, reasonable attorney fees and court costs. I have also been informed of the $50 fee (per RCW 62A.3-515 &620) on checks returned NSF.

Patient OR Legally Authorized Guardian signature ***Date***

P 425.338.4000
F 425.338.4090
www.millcreekfamilypractice.com

Schmidt Medical Center
1025 153rd St. SE, Ste 200
Mill Creek, Washington 98012

Mill Creek Family Practice, PLLC

Notice of Acknowledgement of Privacy Practices and Consent to Discuss Medical Care

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. This is available at the front desk as well as on our website www.millcreekfamilypractice.org. You may see your record or get more information about it by contacting Glynis Thakur, Privacy Officer, at (425) 338-4000.

CONSENT TO DISCUSS MEDICAL CARE

Mill Creek Family Practice, PLLC may discuss my medical information with the following individuals. We may also contact those listed in case of a medical emergency. PLEASE PRINT ALL NAMES LISTED BELOW. PLEASE **DO NOT LIST PHYSICIANS.**

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
EXAMPLE: Jane Doe	Spouse	425-555-1234

VOICEMAIL – CONSENT TO LEAVE DETAILED MEDICAL INFORMATION

I give permission for Mill Creek Family Practice, PLLC to leave detailed medical information at my telephone number(s) below:

☐ ( ) _____ ☐ ( ) _____

OR

☐ **I DO NOT WISH TO HAVE DETAILED MEDICAL INFORMATION LEFT ON VOICEMAIL**

I have reviewed a copy of the Notice of Privacy Practices which provides information about how my health information may be used and disclosed. I have read and understand the Financial Policy of Mill Creek Family Practice, PLLC. I assign payment from my insurance directly to Mill Creek Family Practice, PLLC. I understand that I am financially responsible to MCFP for the charges not paid by insurance and that those charges are due within 30 days of receipt of billing statement. I have authorized MCFP to discuss my medical information with the individuals listed above.

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that MCFP participates in the training of physicians and other healthcare providers and I consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed by MCFP.

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ TODAY'S DATE: _____

Printed Name (If signed on behalf of patient): _____ *Relationship:* _____

Mill Creek Family Practice, PLLC

Financial Policy & Credit Card on File

FINANCIAL POLICY

1. **Payment for all medical care is the patient's responsibility regardless of insurance coverage.**
2. INSURANCE: We participate in most insurance plans and we will bill to your insurance if we are contracted and provided with appropriate documentation. We will also bill most secondary insurances for you. You are responsible for knowing your own insurance benefits and limitations. This includes Accountable Care Networks, Personal Care Networks and/or Limited Network Plans.
3. CO-PAYMENTS: **All copays are due at the time of service.** A $25.00 fee will be charged to any visit at which a copay is not paid at time of service. It is the responsibility of the patient or responsible party to know if your plan requires a copay.
4. NON-COVERED SERVICES: Since the contract between you and your insurance carrier is a private one, we do not routinely research why it has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
5. ACCOUNT BALANCES: **All account balances must be paid within 30 days of receipt of your billing statement.** Failure to pay your balance owed without contacting our Billing Department will result in a delinquent account. If your account remains unpaid, your account may be turned over to an outside collection agency. Any non-sufficient fund checks will be charged a $25 fee. Accounts in Collections are subject to dismissal from the practice.
6. METHODS OF PAYMENT: We accept Cash, Visa, MasterCard and Discover. Established patients may also pay by Check.
7. PERSONAL INJURY CASES: **This office does not bill for motor vehicle accident (MVA), work-related (L&I) or other liability or lawsuit-related cases.** You are responsible for payment at time of service.
8. LATE CANCEL/MISSED APPOINTMENTS: In fairness to other patients and our providers, we ask for at least 24 hours' notice to cancel appointments. If you arrive more than 15 minutes late for your appointment/arrival time, you may be asked to reschedule to another day. **Late cancel (less than 24 hours' notice) and No-Show appointments incur a $50 fee.** If a patient no-shows three or more times within a 12-month period, s/he and any other family members may be dismissed from the practice. It is your responsibility to attend the appointment or give us 24 hours' notice. A confirmatory reminder is a courtesy.
9. DIVORCE/SEPARATION: In cases of divorce and/or separation, the legal guardian and/or the person bringing the child to the **initial visit** will be held financially responsible for payment of medical services.

CREDIT CARD ON FILE

We encourage patients to keep a credit card on file to make the checkout process easier, faster and more efficient. After your insurance has paid its portion of your bill, we will charge your authorized credit or debit card for the amount of the balance. You may specify a maximum amount we may charge your card without contacting you. Credit card numbers are encrypted and stored securely off-site with our bank. No credit card numbers are stored at our office. See "Credit Card on File Frequently Asked Questions" for more information.

I authorize Mill Creek Family Practice, PLLC to keep my credit card on file and charge the portion of my bill that is my financial responsibility.

INITIALS: _____

CARD INFORMATION: *For concern of your privacy, we record the minimum amount of information possible and keep this for verification purposes only.*

☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** **Last 4 Digits:** _____

MAX AMOUNT TO BE CHARGED WITHOUT CONTACTING CARDHOLDER: ☐ $100 ☐ $200 ☐ OTHER $_____

CARDHOLDER NAME: (as it appears on card) _____

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ TODAY'S DATE: _____

Printed Name (If signed on behalf of patient): _____ *Relationship:* _____

MILL CREEK
FAMILY PRACTICE

Schmidt Medical Center
1025 153rd St. SE, Ste 200
Mill Creek, Washington 98012
P 425.338.4000 F 425.338.4090

Patient name:_____ DOB:_____

Important Information on Physicals & Well Child Checks

Please read the following information before your scheduled physical.

1. **A Physical is a "Wellness Visit":**

   - The purpose of this visit is to discuss disease prevention and healthy lifestyle choices, as well as ordering screening lab tests or immunizations.
   - **Your insurance may or may not pay for this visit**
   - A Physical ***does not*** cover discussion or treatment of existing or new medical problems, with a distinct diagnosis, or cover medication refills used to treat your medical problems.
   - Medicare requires us to perform the PHQ9 depression screening test and will pay for this test. However other insurance companies may not cover this. Let your doctor know if you are declining this test, prior to the start of your exam.
   - Lab services, such as bloodwork, urinalysis, pap smears, etc., are billed through outside companies. These laboratories will bill you separately for these services. It is your responsibility to know whether or not these labs are in network with your insurance company.
   - Your provider may request a return visit to discuss abnormal findings on your tests or lab results. ***This visit will not be covered under your Physical, and will be charged as a "Problem-oriented Visit".***

2. **Discussion and treatment of medical problems is a "Problem-Oriented Visit":**

   - While your doctor may be willing to discuss any and all of your medical issues at the time of your Physical, time allowing, be aware that these are not covered in your "Wellness Visit"

3. **Billing for "Physicals" and "Problem-oriented Visits":**

   - Your insurance may be charged for both a "Physical" and a "Problem-oriented Visit".
   - Your insurance company may require a co-pay for both visits
   - If your insurance plan has a deductible, then your insurance will likely apply the "Problem-oriented Visit" toward your deductible.

4. **Your insurance will be charged according to the type of visit(s):**

   - Your provider will code and bill your visit according to the documentation in your medical record. You will be responsible for payment if your insurance company refuses to pay for the visit.
   - The clinic and your provider will not change the type of service billed if your insurance company denies payment. To do so may be in violation of the contract with your insurance company and/or may be construed as insurance fraud.

By signing this, I acknowledge that I have read & understood the above information and agree to pay any additional costs:

Signature of patient (or Guardian if under 18) Printed name Date

Today's Date: _____

MILL CREEK FAMILY PRACTICE

Name:_____ Date of Birth: _____

Please list any medications, vitamins, supplements, or over the counter products you take. Attach additional pages if needed.

Medication Name	Dose/Amount	Frequency/How often

Allergies, if so explain your REACTION: _____

Since your last full physical, have you had any new medical problems, hospitalizations, surgeries?

_____

Are there any new medical problems in your family? Any births or deaths?

_____

Please update:

Relationship Status:_____ for (how long)_____ to (name)_____ (male/female).

Sexually active? Yes / No

Contraception/ Birth control: _____

Tobacco Use: ☐ Never ☐ Former ☐ Current
☐ Cigarettes ☐ Chew ☐ Cigar

Amount of Use: ☐ Daily ☐ Occasional

Year Started:_____ Year Stopped: _____

Packs per Day:_____ Cigars Per Week:_____

Cans per Week: _____

Are you exposed to second-hand smoke? Yes/No

Occupation: _____

Hobbies: _____

Current recreational/illicit drug use:_____

Alcohol Use: No/Yes Type:_____

How many drinks per day? _____

Exercise (type): _____

(number)_____ times per week.

Caffeine use: How many drinks per day? _____

Educational Level:

- ☐ Grade school
- ☐ High school
- ☐ College
- ☐ Graduate school
- ☐ Other: _____

Tests	Date	Results
Pap Smear		Normal / Abnormal
Mammogram		Normal / Abnormal
DEXA bone density		Normal / Abnormal
Colonoscopy		Normal / Abnormal
.....repeat date if known:		
Skin check		
Vision/eye exam		
Immunizations (Tdap, pneumonia, shingles, etc):		

CHILDREN:

NAME	GENDER (M/F)	AGE

Today's Date: _____

MILL CREEK FAMILY PRACTICE

Name:_____Date of Birth: _____

HEALTH HISTORY REVIEW- ADULT

Previous medical history: Check any conditions you have or have had in the past. Please write when it started, if known.

Eg. ☒ Asthma -Oct, 2010

- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disorder
- ☐ Biliary Cirrhosis
- ☐ Blood Transfusions
- ☐ Brain Tumor
- ☐ Cerebrovascular Disease
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ C O P D
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Renal Failure (CRF)
- ☐ Depression
- ☐ Diabetes-Type 1
- ☐ Diabetes- Type 2
- ☐ Diverticulitis
- ☐ Deep Venous Thrombosis (DVT)
- ☐ GI Bleed
- ☐ G E R D
- ☐ Hemochromatosis
- ☐ High Cholesterol (Hyperlipidemia)
- ☐ High Blood Pressure (Hypertension)
- ☐ Hypothyroidism (underactive)
- ☐ Hyperthyroidism (overactive)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Heart Attack (MI)
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Peptic Ulcer Disease (PUD)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ U T I- Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ D E S Exposure
- ☐ Diabetes-Gestational
- ☐ RH Sensitized
- ☐ Uterine Anomaly
- ☐ Sexually Transmitted Diseases/Infections: (name)_____

Surgical History (please note dates if known): Eg. ☒ Appendectomy - Jan, 2000

- ☐ Unremarkable
- ☐ Abd Surg-type
- ☐ Adenoidectomy
- ☐ Amputation
- ☐ Aortic Valve Replacement
- ☐ Appendectomy
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ BA-F Bypass
- ☐ Back Surgery
- ☐ Breast Surgery
- ☐ Bronchoscopy
- ☐ Bilateral Tubal Ligation (BTL)
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel
- ☐ Cataract Extraction
- ☐ Cesarean Section Birth
- ☐ Cholecystectomy
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Dental Surgery:_____
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Interventional Pain Procedures
- ☐ Knee Arthroscopy
- ☐ Knee Replacement
- ☐ Kyphoplasty
- ☐ LA-F Bypass
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mitral Valve Replace
- ☐ Nephrectomy: Native
- ☐ Nephrectomy: Transplant
- ☐ Pacemaker
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ Prostatectomy
- ☐ Percutaneous Transluminal Coronary Angioplasty (PTCA)
- ☐ RA-F Bypass
- ☐ Rotator Cuff Repair
- ☐ Transurethral Resection of Prostate (TURP)
- ☐ Total Hysterectomy (TAH)
- ☐ Oophorectomy (BSO) Right/Left/Both
- ☐ Tonsillectomy
- ☐ Tunneled Dialysis Catheter
- ☐ Uvulopalatopharyngioplasty (UPPP)
- ☐ Urinary Incontinence Surgery
- ☐ Vasectomy
- ☐ Vertebroplasty
- ☐ Other:_____
- ☐ Anesthesia Prob- No
- ☐ Anesthesia Prob- Yes
- ☐ Surgical Complication- No
- ☐ Surgical Complication-Yes
- ☐ Post-op Delirium

MENSTRUAL/REPRODUCTIVE HISTORY (for girls and women):

Number of pregnancies:_____# of births:_____Miscarriages (Ab Spon):_____Abortions (Ab Induc): _____

Age periods started (menarche): _____

Periods/menses occur about once a month?: YES/NO

Date last menstrual period started (LMP): _____ -OR- Menopausal since: _____

Indicate month/year of pregnancies:

Example		1	2	3	4	5	6
June 2008							

Problems with pregnancies or multiples? YES/NO

Today's Date: _____

Name:_____ Date of Birth:_____

Check any conditions you currently have:

GENERAL ☐none
- ☐ fever
- ☐ chills
- ☐ sweats
- ☐ fatigue
- ☐ malaise
- ☐ unexplained weight loss
- ☐ unexplained weight gain
- ☐ excessive sleep
- ☐ inability to sleep

HEART/CARDIOVASCULAR ☐ none
- ☐ chest pains
- ☐ fast or irregular heartbeat (palpitations)
- ☐ fainting (syncope)
- ☐ difficulty breathing with exertion (dyspnea)
- ☐ difficulty breathing when lying down (orthopnea)
- ☐ shortness of breath that awakens you (PND)
- ☐ ankle or feet swelling
- ☐ varicose veins
- ☐ high blood pressures
- ☐ high cholesterol/triglycerides
- ☐ abnormal EKG
- ☐ heart murmur

RESPIRATORY ☐ none
- ☐ cough
- ☐ difficulty breathing (dyspnea)
- ☐ shortness of breath (orthopnea)
- ☐ excessive sputum
- ☐ coughing up blood (hemoptysis)
- ☐ wheezing

CHEST/BREASTS ☐ none
- ☐ lumps
- ☐ breast pain
- ☐ nipple discharge or bleeding
- ☐ change in size
- ☐ skin changes

ABDOMINAL/GASTROINTESTINAL ☐ none
- ☐ upset stomach (nausea)
- ☐ throwing up (vomiting)
- ☐ loose, watery stools (diarrhea)
- ☐ constipation
- ☐ change in bowel habits
- ☐ abdominal pain
- ☐ tarry or bloody stools (melena/hematochezia)
- ☐ yellowing of eye/skin (jaundice)
- ☐ loss of appetite (anorexia)
- ☐ vomiting blood (hematemesis)
- ☐ abdominal pain
- ☐ excessive gas
- ☐ bloating
- ☐ heartburn
- ☐ hemorrhoids

EYES ☐none
- ☐ blurring
- ☐ double vision (diplopia)
- ☐ irritation
- ☐ discharge
- ☐ vision change, loss
- ☐ eye pain
- ☐ sensitivity to light (photophobia)

URINARY/GENITOURINARY ☐ none
- ☐ painful urination (dysuria)
- ☐ blood in urine (hematuria)
- ☐ urinary frequency
- ☐ loss of urine (incontinence)
- ☐ decreased interest in sex (libido)
- ☐ frequency
- ☐ hesitancy
- ☐ frequent nighttime urination (nocturia)
- ☐ genital sores
- ☐ impotence

SEXUAL ☐ none
- ☐ discuss birth control/contraception
- ☐ pain with sex (dyspareunia)
- ☐ skin changes or sores
- ☐ sexually transmitted diseases
- ☐ sexual difficulty

MALE
- ☐ discharge from penis
- ☐ swelling, pain in testicles
- ☐ impotence

FEMALE
- ☐ abnormal vaginal discharge
- ☐ skipped periods (amenorrhea)
- ☐ heavy periods (menorrhagia)
- ☐ abnormal bleeding
- ☐ pelvic/abdominal pain
- ☐ vaginal pain, irritation, itching
- ☐ abnormal pap smears
- ☐ hot flashes

MUSCULOSKELETAL ☐ none
- ☐ back pain
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle cramps
- ☐ muscle weakness
- ☐ stiffness
- ☐ arthritis
- ☐ neck pain
- ☐ numbness
- ☐ limited motion
- ☐ abnormal X-ray

EARS/NOSE/THROAT ☐ none
- ☐ earache
- ☐ hearing loss
- ☐ sinus pain
- ☐ sore throat, hoarseness
- ☐ ear discharge
- ☐ ringing ears (tinnitus)
- ☐ decreased hearing
- ☐ nasal congestion (stuffy nose)
- ☐ nose bleeds
- ☐ trouble swallowing (dysphagia)

SKIN ☐none
- ☐ rash
- ☐ itching
- ☐ dryness
- ☐ suspicious skin changes, lesions
- ☐ changes in moles
- ☐ hair or nail changes
- ☐ abnormal bruising

NEUROLOGICAL ☐ none
- ☐ temporary loss of muscle function (transient paralysis)
- ☐ weakness
- ☐ loss of sensation (paresthesias)
- ☐ seizures
- ☐ fainting (syncope)
- ☐ shakiness (tremors)
- ☐ dizziness (vertigo)
- ☐ headache
- ☐ concerning memory loss

MOOD/PSYCH ☐ none
- ☐ depression
- ☐ anxiety
- ☐ memory loss
- ☐ mental disturbance
- ☐ thoughts of hurting self (SI)
- ☐ seeing/hearing things (hallucinations)
- ☐ paranoia
- ☐ irritablity
- ☐ concern for safety

ENDOCRINE ☐ none
- ☐ cold intolerance
- ☐ heat intolerance
- ☐ excessive thirst (polydipsia)
- ☐ excessive appetite (polyphagia)
- ☐ excessive urination (polyuria)
- ☐ weight change
- ☐ low blood sugar (hypoglycemia)
- ☐ thyroid problem

HEME/LYMPHATIC ☐ none
- ☐ abnormal bruising
- ☐ bleeding
- ☐ enlarged lymph nodes
- ☐ blood disorder
- ☐ anemia

ALLERGIC/IMMUNOLOGIC ☐ none
- ☐ hives (urticaria)
- ☐ hay fever, allergies
- ☐ persistent infections
- ☐ HIV exposure

MILL CREEK FAMILY PRACTICE

Today's Date: _____

MILL CREEK FAMILY PRACTICE

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

FAMILY History: Please indicate if family members have any of the conditions below, and indicate who.

Indicate MATERNAL = mother's side - or - PATERNAL = father's side, if known. Eg. paternal grandmother

Condition	Who	Condition	Who
Alcoholism		**Angina**	
Anesthesia Complication		**Cervical Cancer**	
Anemia		**Heart Attack/Disease (CHD)**	
Anxiety		**in male under 55 yr?**	
Arthritis		**female under 65 yr?**	
Asthma		**Endometriosis**	
Birth Defects, what?		**Growth/Development Probs**	
Bleeding Disorder		**Headaches**	
Breast Cancer		**Lung Cancer**	
Colon Cancer		**Skin Cancer (Melanoma)**	
Depression		**Other Medical Problem**	
Diabetes		**Ovarian Cancer**	
Heart Disease		**PMS**	
High Cholesterol		**Psychiatric Care**	
High Blood Pressure (Hypertension)		**Uterine Cancer**	
Kidney/Renal Disease		**Weight Problems**	
Lung/Respiratory Disease			
Migraines		Other? Please list:	
Osteoporosis			
Seizures			
Severe Allergies			
Stroke/TIA/CVA			
Thyroid Disorder			
Other Cancer			

Are there other concerns you would like to discuss today? (Your provider ***may or may not have time*** to discuss these things, or may prioritize certain concerns based on their clinical urgency. If we discuss or discover any additional problems, ***you may be charged for an office visit, in addition to your physical.***)

_____

_____