NEW PATIENT REGISTRATION

MILL CREEK FAMILY PRACTICE

DEMOGRAPHIC INFORMATION

Patient's Legal Name:			Preferred Name:	Marital Status:
Street Address / PO Box:			**How did you hear about Mill Creek Family Practice?** ☐ Social Media ☐ Family/Friend ☐ Mail/Postcard ☐ Insurance Plan ☐ Web Search ☐ ZocDoc.com ☐ _____	
City:	State:	Zip Code:		
Birth Date:	Age:	Sex: ☐ M ☐ F	Email Address: *(Securely communicate with your Care Team with our Patient Portal)*	
PRIMARY/Cell Phone: *(req.)*	**OTHER** Phone no.: *(optional)*		Preferred contact method: ☐ CELL ☐ HOME ☐ EMAIL	
Preferred Language: ☐ English ☐ Other: _____ ☐ Decline to Answer	Race: ☐ _____ ☐ Multiracial ☐ Decline to answer		Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to answer	

PARENT/GUARDIAN INFORMATION *(for patients under 18)*

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

INSURANCE INFORMATION

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

Primary Insurance:		Secondary Insurance: (if applicable)	
Subscriber: ☐ SELF	Subscriber's DOB:	Subscriber's Name:	Subscriber's DOB:
Copayment: $	Relation to patient:	Copayment: $	Relation to patient:

EMERGENCY CONTACT PREFERENCES

*I allow MCFP to communicate and/or discuss my **Protected Medical Information** with those listed below.*

Emergency/HIPAA Contact Name	Relationship to Patient	Phone Number

May we leave **detailed voicemail** on your primary contact number? ☐ YES ☐ NO

PREFERRED PHARMACY

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

PATIENT ACKNOWLEDGMENTS

I have read and understand the Financial Policy of Mill Creek Family Practice, PLLC. 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 assign payment from my insurance directly to Mill Creek Family Practice, PLLC, and I 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. I allow disclosure of patient's Protected Health Information (PHI) to the individual(s) listed above. I hereby release MCFP from all legal responsibility or liability that may arise from disclosure as provided by this paragraph. 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 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. I authorize treatment of the person named above and agree to pay all fees for such treatment. 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. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance from the date of service, collection fees, reasonable attorney's fees and court costs. I have also been informed of the $50 fee (Per RCW 62A.3-515 & 620) on returned checks NSF.

X

***SIGNATURE** (Patient or Parent/Authorized Representative)*	*Today's Date*

P (425)338-000
F (425)338-4090
www.millcreekfamilypractice.org

Schmidt Medical Center
1025 153rd Street SE, Suite 200
Mill Creek, WA 98012

Mill Creek Family Practice, PLLC

Financial Policy

The providers at Mill Creek Family Practice are committed to providing excellent and affordable care to all of our patients. Your understanding of our Financial Policy, and any changes therein, is important to the establishment and continuation of our relationship as Patient and Provider.

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.
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. PRIVATE PAY APPOINTMENTS: A $90-$150 deposit is required at check in for all patients paying out of pocket for their appointment. At the end of your visit, your card will either be charged the remaining balance, or refunded the difference if the cost of the appointment is less than the deposit made.
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 and major Credit Cards. 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 minor patient to the **initial visit** will be held financially responsible for payment of medical services..

Authorization – Payment Card on File

Due to changes in Healthcare Policy and increasing high-deductible Health Insurance plans, we have unfortunately experienced higher numbers of patients with unpaid medical bills. Therefore, we have implemented a new policy in which ***all patients are required to provide a credit card to be kept securely on file for future account balances.***

Please note that this does not change your existing rights with respect to the use of your card. You are still able or ask for investigation into your insurance company's decision on a claim. Card numbers are stored securely off-site with our bank. Card numbers are not kept in our office.

Co-pays will remain due at time of service as part of the contract between patient and insurance company. We will bill your insurance company(s) following your visit. They are required to send us and you a copy of the Explanation of Benefits letter detailing what amount was covered/paid by your insurance, and what, if any, amount is owed by you, the patient. The card on your account will be charged as payment in full for any remaining balance not paid by insurance. You will receive receipts via email as long as we are provided with your email address.

Transactions are run as credit, not debit, and are listed as "Mill Creek Family Practice" on your credit card statement. If you have any questions about this policy, please contact our Billing office by phone at (425)338-4009.

I have read and understand Mill Creek Family Practice's Financial and Credit Card Authorization Policy and I agree to its terms as stated.

PATIENT NAME: _____ DATE OF BIRTH: _____

CARDHOLDER: ☐ Same as Patient _____ AUTHORIZED LAST 4 DIGITS: _____

CARDHOLDER SIGNATURE: _____TODAY'S DATE: _____

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

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MILL CREEK
FAMILY PRACTICE

Consent to Treat Patient – Without Parent /Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____ **DOB**: _____
Last First Middle

Allergies: _____
Current Medications: _____
Chronic Conditions: _____

For those occasions when you may not be with your child, **please list those individuals who may give us consent** to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

LIMITATIONS:
Identify any **specific limitations** on the kinds of medical services for which this authorization is given.
(If none, state "none")

_____

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult,** which shall be in effect for: □ Date **Only**_____
☐ Indefinitely, until revoked by written communication

AUTHORIZATION:
I (parent/legal guardian name)_____request and authorize Mill Creek Family Practice, PLLC and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child, I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Mill Creek Family Practice, PLLC and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations)
I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____
Parent or Legal Guardian (please print) **Relationship**

_____
Parent or Legal Guardian Signature **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.***)

_____

_____

MILL CREEK
FAMILY PRACTICE

NEWBORN/INFANT HEALTH HISTORY FORM

(Birth to 3 years)

Today's Date: _____

Child's Name: _____ Birthdate: _____ Age: ____

Parent's Name: _____

Current Concerns: _____

_____

Pregnancy History:

1) Problems During Pregnancy: _____
   _____
2) Problems During Labor and Delivery: _____
   _____
3) Born Early/On Time/Late: _____
4) Birth Weight: _____
5) Birth Length: _____
6) Problems of baby at birth or shortly after birth: _____
   _____

Previous Illnesses/Hospitalizations: _____

_____

Previous Surgeries: _____

_____

Current Medications: _____

_____

Allergies: _____

_____

Immunizations and Dates				
Hep B #1	Hep B #2	Hep B #3		
DTaP #1	DTaP #2	DTaP #3	DTaP #4	DTaP #5
Prevnar #1	Prevnar #2	Prevnar #3	Prevnar #4	
HIB #1	HIB #2	HIB #3	HIB #4	
IPV #1	IPV #2	IPV #3	IPV #4	
MMR #1		MMR #2		

Family History	
Check the box if any relative has had that condition/disease. Please write the relationship to the patient.	
☐ Diabetes	☐ Seizures
☐ Heart Trouble	☐ Developmental Delay
☐ High Blood Pressure	☐ Allergies/Asthma/Hayfever
☐ Stroke	☐ Tuberculosis
☐ Cancer	☐ Arthritis
☐ Lung Problems	☐ Obesity
☐ Thyroid Trouble	☐ Mental Illness
☐ Kidney Problems	☐ Other:

Smokers at home? _____ Pets at Home? _____