CONFIDENTIAL MINOR PATIENT INFORMATION

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EVERGREEN CENTER FOR
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2008 NE 65th St
Seattle, WA 98155
(206) 729-0907

Patient Information	First Name:	MI:	Last Name:
Street Address:			
City:	State:		Zip:
SSN:	Gender: ❑ M ❑ F		Home phone:
Date of Birth (mm/dd/yyyy): / /	Age:		Alt phone: ( )
Emergency Contact:		Relationship:	
Home phone:	Work phone:		Cell phone:
Mother's Name:			Birthdate:
Mother's Employer:	Occupation:		Work Phone:
Father's Name:			Birthdate:
Father's Employer:	Occupation:		Work phone:
Referred by:			

Primary Health Insurance	Insurance Company:	Phone: ( )
Claims address:		
Name of Insured:		Insured's Birthdate: / /
Relationship to patient: ❑ Mother ❑ Father ❑ Other:		
ID # on card:		Group #:
Employer of insured:		

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Parent/Guardian Signature _____ Date _____

PEDIATRIC HISTORY	Provide general description and dates for the following (to the best of your knowledge)

Born In: ❑ Hospital ❑ Clinic ❑ Home ❑ Other

Method: _____

List **present** symptoms. List most important first:

Vaccinations:

Operations:

Serious Illnesses:

Medicines taken in last 5 years (include date and duration for major medicines - e.g. Amoxicillin, 3 mos., repeated ear infections 2/97):

Current medications:

Date of last checkup:	Doctor's Name & Phone:		
Birth weight: lbs ounces	Length: inches	Chest:	Head:

List any chemicals, metals, dusts, smoke or fumes your child is repeatedly exposed to:

Does your child react to pollens? If so, which ones?

Does your child react to foods? If so, which ones?

PEDIATRIC HISTORY	Provide general description and dates for the following (to the best of your knowledge)

If your child HAS or DID HAVE any of the following, please check:

❑ Attention Deficit Disorder ❑ Excess Fatigue ❑ Hyperactivity
❑ Colic ❑ Frequent Cough/Wheezing ❑ Insomnia
❑ Eczema ❑ Frequent Infections ❑ Learning Difficulties

❑ Other: _____

FAMILY HISTORY	If family members have had any of the following, please check:

❑ Allergies ❑ Blindness ❑ Heart Disease ❑ Nervous or Mental Disorder
❑ Alcoholism ❑ Cancer ❑ High Blood Pressure ❑ Obesity
❑ Asthma ❑ Diabetes ❑ Hypoglycemia ❑ Tuberculosis
❑ Bleeding Tendency ❑ Epilepsy ❑ Kidney Disease ❑ Other:_____

Which of the above does your child have, if any?

HABITS	Circle appropriate answer below									
Milk / Formula:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Mother's Milk:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Sugars/Sweets:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Fruit Sweeteners:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Fast Food:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Protein Foods:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Vitamins / Minerals:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Aspirin:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day
Laxatives:	never	rarely	frequently	weekly	daily:	once a day	twice a day	3x / day	4x / day	5+x / day

Does your child eat a special diet?

What are your child's favorite foods?

What is your child's general disposition?

How much does your child sleep?

Does your child wear (circle): cloth diapers disposable none

GENERAL

Are you willing to change your habits to help improve your child's health?

Does your child have any other problems you would like to discuss with the doctor?

Consent for Treatment

Methods, Procedures, and Therapeutic approaches: Your physician may perform any of the following procedures as necessary to give proper assessments,determine treatment approaches, treat, or otherwise address your health concerns.

General Diagnostic Procedures: Including but not limited to venipuncture, pap smears, radiology, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Psychological and Lifestyle Counseling, Exercise Prescriptions

Herbs/Natural Medicine: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, and tinctures (which may contain alcohol) topical creams, pastes, plaster washes, suppositories or other forms. Homeopathic remedies (often highly diluted quantities of a naturally occurring substance)may also be used.

Dietary Advice and Therapeutic Nutrition: The use of foods, diet plans, or nutritional supplements for treatment. This may include intramuscular vitamin injections.

Soft Tissue and Osseous Manipulation: The use of massage, neuro-muscular techniques, muscle-energy stretching or visceral manipulations of the extremities and spine including traction and craniosacral therapy.

Potential Risks: May include pain, discomfort, discolorations, infection, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat.or frictional therapies, allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms or conditions.

Potential Benefits: Restoration of health and the body's maximum functional capacity, relief of pain,and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they suspect or know they are pregnant, as some of the therapies used could present a risk to the pregnancy.

Statement of Consent For Treatment:

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participating in these procedures at any given time. With this knowledge,I voluntarily consent to the above procedures, realizing and acknowledging that no guarantees have been given to me by my doctor/practitioner or any of their personnel regarding cure or improvement of my condition(s). I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or as otherwise permitted by law.

_____	_____	_____
Guardian/PatientsName(print)	Guardian/Patients Signature	Date

Evergreen Center for Integrative Medicine
2008 NE 65th St * Seattle, WA 98115
Phone: 206-729-0907
Fax: 206-729-0199

Patient-Practitioner Relationship

I understand that I am a patient of_____, who is an independent practitioner at The Evergreen Center for Integrative Medicine. The Evergreen Center is not a group practice, but rather a facility where independent practitioners share office space. I understand that my medical care is the sole responsibility of the individual practitioner, not The Evergreen Center for Integrative Medicine or any of the other practitioners who may practice there.

If I am seeing more than one practitioner at this clinic, I understand that each practitioner is required to keep separate records and will be billing for services separately from any other practitioners at this clinic.

_____ _____

Patient Name (please print) Date

_____ _____

Patient/Guardian Signature Relationship to Patient

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Notice of Privacy Practices

The Evergreen Center for Integrative Medicine (ECIM) is required to provide you with a copy of its "Notice of Privacy Practices" document and to obtain written acknowledgement, if possible, that you have received it. This notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:
* Provide and coordinate my treatment
* Obtain payment from third-party payers for my health care services
* Conduct normal health care operations such as quality assessment and improvement activities

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy.

My signature below acknowledges that I have (please check one):

_____ been offered a copy of the Notice of Privacy Practices document and have accepted that copy.

_____ been offered a copy of the Notice of Privacy Practices document and have declined a copy. I understand that I can request a copy at any time in the future, and be given a current copy.

_____	_____	_____
Patient/Guardian Signature	Relationship to Patient	Date

Office Use Only

I hereby affirm that ECIM has made a good faith effort to provide a copy of the Notice of Privacy Practices to the above named patient and to obtain written acknowledgement of such.

Staff Initials: _____
Staff please check one:

_____ Pt offered but refused to sign _____ Pt. physically unable to sign

_____ Communication barrier / other reason: _____

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