

New Patient Health Record

At Water's Edge, our naturopathic doctors take the time to learn all about your health history and help you achieve your wellness goals. Please complete and return this **Patient Health History form** to tell us important information about you.

NP

**Please call our office and schedule a new patient appointment *before* you fill out and submit this questionnaire.**

**Return your completed form to us at least 48 HOURS before your first appointment.**

**How to complete and return this form to us:**

1. Complete the form using Microsoft Word. Save the file with a new filename that includes **your name** (e.g., "*New-*Patient-Health-Record-MarySmith.doc").  
   (NOTE: Please do not convert it to another format such as HTML.)
2. Return the form to us by mail or fax:

Send to: 1000 2nd Ave, Suite 2920 Seattle, WA 98104

FAX: 206.283.1924

**NOTE**: If you are unable to send this form in email, please print your completed form and mail it to our office at the address below. \*\***Be sure to mail it at least 5 days before your appointment, so we receive it 24-48 hours in advance**.

If you have any questions, please call us at **206. 283. 1383**.

Thank you, and we look forward to working with you!



New Patient Health Record

New Patient Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NP

|  |  |  |
| --- | --- | --- |
| Patient’s Information |  | Account Information |
| Name  Prefer to be called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Spouse/Partner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address  City State Zip \_\_\_\_\_\_\_\_  Home Phone  Work Phone  E-mail Address  Birth Date Age \_\_\_\_\_\_ Gender: ¨ Female ¨ Male  Marital Status: ¨ Married ¨ Partnered ¨ Single ¨ Divorced ¨ Widowed ¨ Separated | Person responsible for the account \_\_\_  Occupation  Employer  Business Address  City State Zip  Business Phone |
| Your Spouse/Partner |
| Occupation  Employer  Business Address  City State Zip  Business Phone |
| General Information |
| Do you have a Primary Care Doctor? ¨ No ¨ Yes  Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you consulted a doctor about your current condition(s)? ¨ No ¨ Yes  Please state diagnosis, therapy and the results: |
| Person to Contact in Case of Emergency |
| Name  Relationship  Address  City State Zip  Telephone |

**\*Authorization for Treatment**

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the Standards of Naturopathic Care.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History**

Patient’s Name Date

Number of Children Names & Ages

Current Health Condition

(Please list your present health problems and concerns.)

|  |  |
| --- | --- |
| **Problem or Concern** | **Date of Onset** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

Please list the most significant, stressful events in your life, from the most recent to the most distant.

Are any of these situations continuing to impact your life? If so, please indicate these clearly.

|  |  |
| --- | --- |
| **Event** | **Continuing?** |
|  | ¨ Continuing |
|  | ¨ Continuing |
|  | ¨ Continuing |
|  | ¨ Continuing |

Family Medical History

From the following list, please write next to each family member all conditions that apply.

|  |  |  |  |
| --- | --- | --- | --- |
| **Conditions** | |  | Family members affected |
| AIDS | HIV+ |  | Mother: |
| Alcoholism | Kidney disorder |  |  |
| Allergies | Mental illness |  |  |
| Anemia | Migraines |  | Father: |
| Arthritis | Obesity |  |  |
| Asthma | Osteoporosis |  |  |
| Breast Cancer | Psoriasis |  | (Maternal) Grandparents: |
| Cervical Cancer | Senility |  |  |
| Ovarian Cancer | Seizures |  |  |
| Prostate Cancer | Sexually Transmitted Disease |  | (Paternal) Grandparents: |
| Uterine Cancer | Skin problems |  |  |
| Other Cancers (list types) | Stroke |  |  |
| Diabetes | Suicide |  | Siblings: |
| Eczema | TB |  |  |
| Gout | Thyroid problems |  |  |
| Heart Disease | Ulcer |  | Other Family: |
| Hemophilia | Other |  |  |
| High blood pressure |  |  |  |

Name Date

Medications and Hospitalizations

Please include all your current **prescription medications** (sleeping pills, birth controls pills), **non-prescription medications** (aspirin, antacids, laxatives, antihistamines), vitamins, minerals, herbs, etc. (**Include dose for each**.)

Attach a separate sheet, if necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose per day** | **Reason for use** | **Prescriber** | **Date started Med.** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Hospitalization, surgeries or serious injuries (dates and types of illness or operation):** | | | | |
|  | | | | |
|  | | | | |
|  | | | | |

Allergies

|  |  |
| --- | --- |
| **Drugs, food or other substances** | **Reaction** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Name Date

Health Data

**(Please fill in completely)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Exam** | **Date** | **Result** | **Due** | **Screening Recommendations** |
| Last Pap Smear/Gynecologic Exam |  |  |  | Yearly starting after first intercourse or age 21 |
| Mammogram |  |  |  | Yearly starting at age 40 |
| Bone Density Test (DEXA) |  |  |  | Every 2 years starting at age 50 |
| Colonoscopy |  |  |  | Every 10 years starting at age 50 |
| Prostate or Testicular Exam |  |  |  | Yearly for men starting at age 40 |
| **Other** | **Date** | **Location** | **Result** | |
| Physical Exam |  |  |  | |
| Foreign Travel History & Immunizations |  |  |  | |
| Tuberculosis (TB) skin test |  |  |  | |
| Diagnostic Imaging (X-Ray, Ultrasound, MRI, CT, Angiogram, etc.) |  |  |  | |
| Other |  |  |  | |

Health History

Please check any conditions you **currently** **have** or **have had in the** **past year ONLY**.

|  |  |  |  |
| --- | --- | --- | --- |
| **General** | **Gastrointestinal** | **Eye/Ear/Nose/Throat** | **Cardiovascular** |
| ¨ Chills  ¨ Depression  ¨ Dizziness  ¨ Fainting  ¨ Fever  ¨ Forgetfulness  ¨ Headache  ¨ Loss of sleep  ¨ Nervousness  ¨ Numbness  ¨ Sweats | ¨ Poor Appetite  ¨ Bloating  ¨ Bowel changes  ¨ Constipation <1 stool/day  ¨ Diarrhea  ¨ Excessive hunger  ¨ Excessive thirst  ¨ Gas  ¨ Hemorrhoids  ¨ Indigestion  ¨ Nausea  ¨ Rectal bleeding  ¨ Stomach pain  ¨ Vomiting  ¨ Vomiting blood  ¨ Parasites | ¨ Bleeding gums  ¨ Blurred vision  ¨ Crosses eyes  ¨ Difficulty of swallowing  ¨ Double vision  ¨ Ear ache  ¨ Ear discharge  ¨ Hay fever  ¨ Hoarseness  ¨ Loss of hearing  ¨ Nosebleeds  ¨ Ringing in the ears  ¨ Sinus infections  ¨ Vision “flashes”  ¨ Vision “halos” | ¨ Chest pain/pressure  ¨ High blood pressure  ¨ Irregular heart beats  ¨ Low blood pressure  ¨ Poor circulation  ¨ Rapid heart beat  ¨ Varicose veins  ¨ Edema |

Name Date

**Health History** (continued)

Please check any conditions you **currently** **have** or **have had in the** **past year ONLY**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Respiratory** | **Skin** | **Muscle/Joint/Bone** | **Genito-Urinary** |
| ¨ Shortness of breath  ¨ Persistent cough  ¨ Wheezing  ¨ Cough with blood | ¨ Acne  ¨ Bruise easily  ¨ Itching  ¨ Change in mole(s)  ¨ Rash  ¨ Scars  ¨ Sore that won’t heal | Pain, weakness, or numbness in:  ¨ Arms  ¨ Back  ¨ Feet  ¨ Hands  ¨ Hips  ¨ Legs  ¨ Neck  ¨ Shoulders  ¨ Loss of height | ¨ Blood in the urine  ¨ Frequent urination  ¨ Lack of bladder control  ¨ Painful urination |

Please CHECK any conditions you **currently have** or **have ever had**.

|  |  |  |
| --- | --- | --- |
| ¨ AIDS | ¨ Frequent antibiotic use | ¨ Panic attacks |
| ¨ Alcoholism | ¨ Hay fever | ¨ Parasites |
| ¨ Allergies | ¨ Headaches | ¨ Pneumonia |
| ¨ Anemia | ¨ Hemorrhoids | ¨ Prostate problems |
| ¨ Anorexia | ¨ Hemophilia | ¨ Psoriasis |
| ¨ Appendicitis | ¨ Problems with gums and teeth | ¨ Psychiatric care |
| ¨ Arthritis | ¨ Gall bladder problems | ¨ Rheumatic fever |
| ¨ Asthma | ¨ Glaucoma | ¨ Spontaneous abortion (miscarriage) |
| ¨ Bladder/urinary problems | ¨ Goiter | ¨ Seizures |
| ¨ Bleeding disorders | ¨ Gout | ¨ Sexual abuse |
| ¨ Breast lump | ¨ Hair falling out | ¨ Sinusitis |
| ¨ Bronchitis | ¨ Heart Disease | ¨ Skin problems |
| ¨ Bulimia | ¨ Hernia | ¨ Stroke |
| ¨ Cataracts | ¨ High Cholesterol | ¨ Suicidal attempt |
| ¨ Cancer (list type) | ¨ Hypoglycemia | ¨ Thyroid problems |
| ¨ Chemical dependency | ¨ Irritable bowel/colitis | ¨ Tonsillitis |
| ¨ Diabetes | ¨ Jaundice | ¨ Ulcers |
| ¨ Digestive disorders | ¨ Joint problems | ¨ Varicose veins |
| ¨ Ear problems | ¨ Kidney disease | ¨ Vaginal infections |
| ¨ Edema, dropsy or water weight | ¨ Liver disease | ¨ Weight gain/weight loss |
| ¨ Eczema | ¨ Lung problems | ¨ Other: |
| ¨ Emphysema | ¨ Migraine headaches |  |
| ¨ Epilepsy | ¨ Multiple sclerosis |  |
| ¨ Eye problems | ¨ Obesity |  |
| ¨ Fatigue (chronic) | ¨ Osteoporosis |  |
| ¨ Female gynecological problems | ¨ Pacemaker |  |

Name Date

**Health History** (continued)

Please CHECK any conditions you **currently have** or **have ever had**.

|  |  |  |
| --- | --- | --- |
| **Infectious diseases:** | | |
| ¨ Chicken pox | ¨ Measles | ¨ Scarlet fever |
| ¨ Chlamydia | ¨ Mumps | ¨ Syphilis |
| ¨ Gonorrhea | ¨ Mononucleosis/Epstein-Barr | ¨ Tuberculosis |
| ¨ Hepatitis | ¨ Polio | ¨ Typhoid fever |
| ¨ Herpes | ¨ Papilloma virus | ¨ Other: |
| ¨ HIV positive | ¨ Rubella |  |

Please CHECK Yes or No for any conditions you **currently have** or **have ever had**.

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | Breast/Prostate cancer |
| **Yes** | **No** | Uterine/Cervical cancer |
| **Yes** | **No** | Currently pregnant |
| **Yes** | **No** | Currently breastfeeding |
| **Yes** | **No** | Heart or Liver or Kidney disease |
| **Yes** | **No** | Thrombophlebitis (deep vein pain/clotting issue) |
| **Yes** | **No** | Thromboembolic disorder (blood clotting problem) |
| **Yes** | **No** | Estrogen-related cancer |
| **Yes** | **No** | Undiagnosed abnormal genital bleeding |
| **Yes** | **No** | Family history of Breast cancer |
| **Yes** | **No** | Family history of Uterine cancer or Cervical cancer or Prostate cancer |
| **Yes** | **No** | Breast cysts, breast nodules, fibrocystic breasts, abnormal mammogram |
| **Yes** | **No** | Severe liver disease |
| **Yes** | **No** | History of severe hypersensitivity to drugs |
| **Yes** | **No** | Genital cancer (Vaginal or Testicular cancer) |
| **Yes** | **No** | Use of blood thinning medications |
| **Yes** | **No** | Severe reaction to estrogen or progesterone or testosterone or DHEA or Cortisol |
| **Yes** | **No** | Currently active cancer |
| **Yes** | **No** | Myocardial infarction or other acute heart disease |
| **Yes** | **No** | High blood pressure or intracranial hypertension |
| **Yes** | **No** | BPH (Benign Prostatic Hypertrophy) causing obstructed urine flow |

If you answered **Yes** to any of the above, please describe in detail.

|  |
| --- |
|  |
|  |
|  |
|  |

Name Date

Hormone Medication History

**Please complete the following table, using the examples below.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hormone** | **DHEA** | **Progesterone** | **Estrogen** | **Testosterone** |
| Hormone Name |  |  |  |  |
| Dosage |  |  |  |  |
| Date Started |  |  |  |  |
| Date Ended |  |  |  |  |
| Using Currently |  |  |  |  |
| Days of month used |  |  |  |  |
| Natural |  |  |  |  |
| Synthetic |  |  |  |  |
| Cream |  |  |  |  |
| Suppository |  |  |  |  |
| Caps/Tablets |  |  |  |  |
| Drops |  |  |  |  |

|  |
| --- |
| Reason for use: |
| List reactions to hormones: |

**EXAMPLE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hormone** | **DHEA** | **Progesterone** | **Estrogen** | **Testosterone** |
| Hormone Name |  | Prometrium | Estradiol |  |
| Dosage |  | 100 mg | 1.0 mg |  |
| Date Started |  | 6/05 | 6/05 |  |
| Date Ended |  |  |  |  |
| Using Currently | No | Yes | Yes | No |
| Days of month used |  | Days 15-30 | Days 1-20 |  |
| Natural |  |  |  |  |
| Pharmaceutical |  | Yes | Yes |  |
| Cream |  |  |  |  |
| Suppository |  |  |  |  |
| Caps/Tablets |  | Yes | Yes |  |
| Drops |  |  |  |  |

Name Date

**Personal Health Habits**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Height: | Current Weight (lbs): | | | 1 Year Ago (lbs): | | Max. Weight (lbs): | Date: | |
| **Item** | **No** | **Yes** | **Details** | | | | | |
| Tobacco Use |  |  | Smoke or Chew: Years: | | Amt Per Day: | | | Year Quit: |
| Alcohol Use |  |  | Type: | | Drinks per week: | | | |
| Rec. Drug Use |  |  | Type: | | Frequency: | | | |
| Coffee: |  |  | Cups Per Day: | | Caffeinated or Decaf: | | | |
| Tea |  |  | Cups Per Day: | | Caffeinated or Decaf: | | | |
| Sodas |  |  | Type: | | Cans Per Day: | | | |
| Chocolate |  |  | How Often: | | | | | |
| Exercise |  |  | Type: | | Frequency: | | | Duration: |

**Occupational and Household Exposure**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| What is your occupation? | | | | | Average hours you work per week: |
| Please describe your work: | | | | | |
| **Situation** | **No** | **At Times** | **Yes** | **Details** | |
| Do you work in the presence of toxic fumes or chemicals? |  |  |  |  | |
| Have you ever worked near toxins? |  |  |  | If yes, please provide details: | |
| Are you exposed to second-hand smoke? |  |  |  |  | |
| Do any of your hobbies involve toxic materials? |  |  |  | If yes, what kind (paints, plastics, gases, lead, etc.): | |
| Do you wear sunglasses, contact lenses, or glasses when outside? |  |  |  |  | |
| Do you have house pets? |  |  |  | Type: | |

Detoxification

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Situation** | **No** | **At Times** | | **Yes** | **Details** |
| Have you ever participated in a detox program supervised by a qualified health professional? |  |  | |  | If yes, please explain: |
| Do you fast? |  |  | |  |  |
| Do you feel well rested on waking in the morning (ready to get up and going)? |  |  |  | |  |
| How many hours do you sleep on the average night? | | | | | |
| On a scale from 1 to 10, how do you rate the quality of your sleep? (0 = no sleep and 10 is great): | | | | | |

Name Date

Digestion and Eating Habits

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Description of diet** | **No** | **At Times** | | **Yes** | | **Details (Describe each meal below)** |
| Do you eat **breakfast**? |  |  | |  | |  |
| Do you eat **lunch**? |  |  | |  | |  |
| Do you eat **dinner**? |  |  | |  | |  |
| Do you eat **snacks**? |  |  | |  | | Number of times a day:  What do you eat? |
| Do you diet often? |  |  | |  | |  |
| Are you on a special diet? |  |  | |  | | If yes, describe: |
| What kind of foods do you **crave**? | List: | | | | | |
| What kinds of foods cause you **problems**? | Describe the food and the problem you experience when you eat it: | | | | | |
| What foods do you eat every day? |  |  |  | |  | |
| Do you often eat at fast-food restaurants? |  |  |  | |  | |
| Do you often eat in restaurants? |  |  |  | |  | |
| Do you use NutraSweet (aspartame)  or other artificial sweeteners? |  |  |  | |  | |
| How do your bowel movements tend to be? | ¨ Constipated ¨ Loose ¨ IBS ¨ IBD ¨ \_\_\_\_\_\_\_\_ | | | | | |

Skin

|  |
| --- |
| Do you perspire when you exercise? ¨ Lightly ¨ Moderately ¨ Heavily |
| Do you perspire other than when exercising? ¨ No ¨ At Times ¨ Yes When? |
| Do you have difficulty perspiring? ¨ No ¨ At Times ¨ Yes |
| Does your perspiration smell strong? ¨ No ¨ At Times ¨ Yes  Does it smell like urine? ¨ No ¨ At Times ¨ Yes |

**Life Style Index**

**Please rate your level of functioning for each area of your life on a scale of 1-10 (10 = best)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Function** | **Rating** | **Function** | **Rating** | **Function** | **Rating** |
| Mental |  | Family |  | Social |  |
| Emotional |  | Creativity |  | Spiritual |  |
| Physical |  | Fun |  | Career |  |

Name Date

**Vitality Survey**

**Scoring: Never —0 Seldom — I Occasionally —2 Often —3 Very Often —4**

|  |  |
| --- | --- |
| **How often do you…** | **Score** |
| Lose your sense of humor/take life too seriously? |  |
| Experience doubt or indecision? |  |
| Experience worry and anxiety? |  |
| Feel over-cautious or pessimistic? |  |
| Lack self-confidence or feel low self-esteem? - |  |
| Experience stress or feel nervous or tense? |  |
| Feel irritable or oversensitive? |  |
| Experience difficulty concentrating and loss of clear thought? |  |
| Experience inadequate energy (fatigue)? |  |
| Have coffee, tea, tobacco, sugar or other stimulants as a pick up? |  |
| Experience nervous indigestion? |  |
| Experience loss of sex drive? |  |
| Experience difficulty sleeping? |  |
| Experience difficulty getting up in the morning? |  |
| Feel run down? |  |
| Feel depressed? |  |
| Feel like crying for no reason? |  |
| Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc.)? |  |
| Find it difficult to express your feelings? |  |
| Experience rapid heartbeat or panic? -. |  |
| Feel moody? |  |
| Feel suicidal or wonder whether life is worth living? |  |
| Have anxiety about not having enough money? |  |
| Fear ill health? |  |
| Fear criticism? |  |
| Fear loss of love? |  |
| Fear old age or death? |  |
| Feel “something is the matter with me” but don’t know what? |  |
| Think that you might be going crazy (losing it)? |  |
| **TOTAL SCORE:** |  |

|  |  |
| --- | --- |
| 0 — 30 POINTS = Powerful Nerve Force HIGH VITALITY  31— 45 POINTS = Strong Nerve Force GOOD VITALITY  46 — 60 POINTS = Moderate Nerve Force AVERAGE VITALITY  61 — 75 POINTS = Low Nerve Force LOW VITALITY | 76 — 90 POINTS = Nervous Fatigue NERVOUS FATIGUE  91 — 105 POINTS = Nervous Depletion NERVOUS EXHAUSTION  106 — 120 POINTS = Serious Nervous Exhaustion SEVERE BURNOUT |

Name Date

**Women Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Gynecologic History** | **Yes** | **No** | **Details** |
| Age your period began: | | | **Abnormal Pap smear? Date:** |
| Menopause |  |  | If yes, date of last period: |
| Perimenopause |  |  | If yes, describe symptoms: |
| Ovaries removed (one/both) |  |  | If yes, when: |
| Uterus removed |  |  | If yes, when: |
| DES – did your mother take it during pregnancy? |  |  |  |
| **Are you still menstruating?** |  |  | **If yes, complete the section below; if no, skip that section** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Menstruation** | **Yes** | **No** |  | **Yes** | **No** |
| Regular periods |  |  | Bleeding between periods |  |  |
| Irregular menses  Symptoms: |  |  | Spotting |  |  |
| Cramps / # of days:  Mild\_\_\_ moderate\_\_\_ severe\_\_\_\_ |  |  | Midcycle spotting |  |  |
| PMS / # of days:  Symptoms: |  |  | Spotting instead of period |  |  |
| Oral contraceptives (past/present) |  |  | Weight gain (how many lbs) |  |  |
| Periods every \_\_\_\_\_days (length of cycle) Duration: \_\_\_\_\_ days (flow days) Flow: heavy\_\_ medium\_\_\_ light\_\_\_ | | | | | |
| Date your last 6 periods began: \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ | | | | | |

|  |  |
| --- | --- |
| **Pelvic Exam** | |
| Date of last pelvic exam: | Performed by: |
| Date of last PAP smear: | Result: |
| Recurrent vaginal yeast infections Yes\_\_\_\_ No \_\_\_\_ | Are you sexually active: Yes\_\_\_\_ No \_\_\_\_\_\_ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Breast Health** | **Yes** | **No** |  | **Yes** | **No** |
| Breast pain |  |  | Fibrocystic breast disease |  |  |
| Breast lumps |  |  | Do you perform monthly breast exam on yourself? |  |  |
| History of abnormal mammogram |  |  | Currently breastfeeding |  |  |
| Nipple discharge |  |  | Breast implants / Type: |  |  |
| **Date of last mammogram: Results: Location of diagnostic center:** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Pregnancy** | **Yes** | **No** |  | **Yes** | **No** |
| Currently pregnant |  |  | Planning pregnancy (If yes, when: ) |  |  |
| Desire pregnancy |  |  | Pregnancy complications (If yes, describe) |  |  |
| Prior pregnancies: #\_\_\_ Births #\_\_\_ C-Sections #\_\_ Miscarriages #\_\_\_ Abortions #\_\_\_\_ | | | | | |

Name Date

**Female Hormone Imbalance Rating**

Please rate the severity of the symptom(s) or condition **if it’s present** by rating it on a **Wellness Gauge Scale** **0 to 10   
when 0 = symptom is not present ☺ and 10 = symptom is severe ☹**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Fibroids |  | Mood swings |
|  | Allergies |  | Fluid retention |  | Night sweats |
|  | Anger easily |  | Food cravings/binge eating |  | Ovarian cyst(s) |
|  | Back pain |  | Heavy menstrual bleeding |  | PMS |
|  | Bloating |  | Vaginal dryness |  | Rheumatoid arthritis |
|  | Chronic stress |  | Hot flashes |  | Skin problems |
|  | Depression |  | Insomnia |  | Spotting |
|  | Disinterest in sex/low sex drive |  | Irregular menstrual cycle |  | Subfertility |
|  | Endometriosis |  | Irritable or anxious |  | Other: |
|  | Fatigue |  | Meat eater (rate frequency) |  |  |
|  | Fibrocystic breast disease |  | Menstrual migraines |  |  |
|  | | | | **TOTAL SCORE:** | | |

**Past or Present Condition (0 = none, 10 = yes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Ovarian Cancer |  | Infertility (never able to conceive) |
|  | Uterine Cancer |  | Loss of height/ bone loss |
|  | Cervical Cancer |  | Miscarriage |
|  | Breast Cancer |  | Premature menopause (<45 yrs old) |
|  | Estrogen/Progesterone sensitive Cancer |  | Pain with intercourse |
|  |  |  | **TOTAL SCORE:** |
|  | | | **GRAND TOTAL SCORE:** |

|  |
| --- |
| **Are you completely satisfied with your sexual experience:** Yes\_\_\_\_ No \_\_\_\_ |
| Please explain: |
|  |
|  |

Name Date

**Men Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Breast lump |  |  | DES – did your mother take it during pregnancy? |  |  |
| Lump in testicle |  |  | Date of last genital exam: |  |  |
| Penis discharge |  |  | Date of last prostate exam: | | |
| Sore on the penis |  |  | Date of last PSA test: Result: | | |
| Erection difficulties |  |  |  | | |

**Male Hormone Imbalance Rating**

Please rate the severity of the symptom(s) or condition **when it’s present** by rating it on a **Wellness Gauge Scale 0 to 10,   
when 0= symptom is not present ☺, 10= symptom is severe ☹**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Thinning armpit, head, pubic hair |  | Urine flow dribbling at the end |
|  | Joint pain/Stiffness |  | Skin problems/dryness |  | Blood in urine |
|  | Anger easily |  | Excessive sweating (day or night) |  | Urinary incontinence |
|  | Back pain |  | Mood swings |  | Pain with urination |
|  | Rheumatoid arthritis |  | Lack interest in leisure/social activities |  | Pain with ejaculation |
|  | Chronic stress |  | Low stamina |  | Bloody ejaculation |
|  | Depression |  | Difficulty obtaining erection |  | Pain with intercourse |
|  | Disinterest in sex/low sex drive |  | Difficulty maintaining erection |  | Unable to conceive (subfertility) |
|  | Erectile dysfunction |  | Pain with erection |  | Mass in genital organs |
|  | Fatigue |  | Lack of nocturnal erections |  | Heavy drinking (past/ present) |
|  | Insomnia |  | Lack of morning erections |  | Frequent urination |
|  | Irritable or anxious |  | Urine flow slow to start |  | Other: |
|  | Food cravings/binge eating |  | Weak urine stream |  |  |
|  | Breast enlargement |  | Unable to void bladder completely |  |  |
|  | | | | **TOTAL SCORE:** | | |

**Past or Present Condition (0 = none, 10 = yes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | History of mumps infection |  | Infertility (never able to conceive) |
|  | History of mass in genitalia |  | Loss of height/bone loss |
|  | History of testicular/scrotal surgery |  | Cancer: (list type) |
|  | Developmental issues w/sex organs |  | Other: |
|  | Family history of prostate cancer |  | **TOTAL SCORE:** |
|  | | | **GRAND TOTAL SCORE:** |

\***Office Guidelines**

Please read and sign our office guidelines to ensure we share a common understanding. We welcome any questions you may have, and if there’s anything we haven’t covered, please feel free to ask. We want to have all your questions answered so we can move ahead with your healing process. Thank you-- we look forward to helping you!

**Payment for Services, Lab Test and Health Products**

* **Full payment is required at the time of service**. It has been our experience that people get well faster if they don’t have to worry about doctor bills piling up. **Initial:\_\_\_\_\_\_**
* **All in-person/phone visits will be paid in full at the end of your visits**. **Payment method on file will automatically be processed unless another method is provided. Initial:\_\_\_\_\_\_**

**Insurance billing/Medical Forms**

* We do not bill insurance companies or communicate with them. We will provide you with an itemized invoice you can try to submit it to your insurance company for reimbursement (please contact your insurance company how to proceed.) For more information, please see ***Chapter 1: Payment Options & Insurance***. **Initial for Acknowledgement: \_\_\_\_\_\_**
* Forms/Letters: 1) If you have an insurance denial coverage and you want your provider to write an appeal letter. 2) FMLA letters 3) Medical Necessity letter. The processing fee is **$80**, payment is due when the forms/letter are requested. We require 5-7 business day turnaround time. 3) Prior authorizations for prescriptions are **$50** fee (per prescription/per year). **Initial for Acknowledgement: \_\_\_\_\_\_**

**Payment Method**

* Water’s Edge accepts all major credit cards/debit, check or cash. Please note the credit card machine adds a 3% surcharge on credit cards and no surcharge on debit cards. There will be a $40.00 charge for returned checks. **Initial for Acknowledgement: \_\_\_\_\_\_**

**Office Hours, Appointments, Cancellations, Reschedules, No Shows**

* Hours may vary due to holidays and clinic closures. Whenever possible we post notification of changes to our regularly scheduled ours.
* If you need to cancel or change a scheduled appointment, please call Monday - Friday during or before office hours, (2) or more business days before your appointment.
* Arriving on time for all appointments and understand: Arriving more than **15 minutes late** is considered a **no-show**. Appointments that run **over the scheduled time,** may incur **additional fees after 10 minutes**.
* **If a change is made with less than 48 hour business notice, you will be charged the full visit fee. Initial:\_\_\_\_\_\_**

**Medical messages and questions**

* If you have a brief question about your care that can be answered by our staff, there is no charge. If you call about a new health concern or need to talk directly with one of the doctors, ***the cost is $80 for up to 10 minutes***; calls longer than 10 minutes are charged the full office visit fee. **Initial:\_\_\_\_\_\_**
* Lab results must be obtained directly from your doctor during a visit before we can change your treatment plan. **Initial:­­­\_\_\_\_\_\_\_**

**Refilling and Mailing your Medications**

* You may come to our clinic any time during normal business hours to purchase medications prescribed for you. For best service, please call several days in advance to allow the doctor to authorize the refills and quantities you have requested**.** Your Personalized Care Plan indicates how many refills the doctor has ordered. ***Prescriptions requiring a re-test will not be renewed until the test results have been reviewed by the doctor.*** Please be prepared to wait briefly, as we may be serving other patients, and will process your order as soon as possible after you arrive. **Initial:\_\_\_\_\_\_**
* We are happy to mail medications your doctor has prescribed for you. A handling charge is added to the postage fee for all mailings, to cover the cost of shipping supplies. Orders are generally processed 24 to 48 business hours from when they are placed. Requests made on Thursday after 12 pm PST, will not go out until the following week. Mailed items must be paid for at the time of the order**. Please note we cannot be responsible for lost packages; *if you request a mailing or drop box you assume the risk and cost.* Initial for Acknowledgement: \_\_\_\_\_\_**
* In addition, for any orders placed over the phone or email, our staff will charge credit card on file. **Please specify which credit card you would like to use and if it is a pick-up or mail out.**

**Return & Test kit Policy**

* You may return any unopened, unexpired medicines purchased within 30-days (for office credit); after that, all sales are final. **Initial:\_\_\_\_\_\_**
* All labs are non-refundable once processed and charged. **Initial:\_\_\_\_\_\_**
* Test kits are non-refundable after 30-days of purchase, after that all sales are final. **Initial:\_\_\_\_\_\_**
* All resubmissions now have expiration dates. You have 60 days to complete and send in the resubmission test kit, after that 60 days test kits would need to be purchase in full. **Initial:\_\_\_\_\_\_**
* All test kits must be completed by the 6 months grace period of the original purchase date. If you need any replacements after the 6 months there will be a full charge replacement fee. **Initial:\_\_\_\_\_\_**

I accept the above Office Guidelines. **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**\*Consent for Leaving Messages/Share Information with Family/Friends**

I understand that my healthcare information at Water’s Edge Natural Medicine is protected, and I have received a copy of the Notice of Privacy Practices.

In order for the clinic to leave detailed messages on my voice mail or answering machine, I need to give permission to Water’s Edge Natural Medicine.

**Consent for Leaving Messages** (please check box)

□ Yes □ No best number to leave messages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to information regarding myself (or my child’s) appointment reminders/instructions

be left on my voicemail or answering machine.

**Consent for Shared Information with Family and Friends** (please check box)

□ Yes □ No

I wish family members or friends to have access to my healthcare information. The name(s)

listed below are family members or friends to whom I grant access to my healthcare information.

I will rely on the professional judgment of my provider and her designee to

share such information as they deem necessary.

I understand that information is limited to verbal discussions; no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

NAME RELATIONSHIP

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name Patient/Parent Signature**

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships change and may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

**\*Doctor and Patient Information & Responsibilities**

***Water’s Edge Clinic***

At Water’s Edge Clinic, we believe healing is a partnership. When both doctor and patient commit to clear communication, mutual respect, and shared responsibility, the outcomes are more positive and lasting.

This document outlines our commitments to you, as well as what we ask of you as a patient, so we can create the best possible care experience—together.

**As Your Doctor, I Commit To:**

* Treating you with compassion and respect. I will listen and communicate clearly.
* Honoring your health choices and personal preferences.
* Collaborating with other healthcare providers as part of your broader care team, when appropriate.
* Responding to your phone messages through my staff in a timely manner.
* Staying current in my fields of training and interest by attending ongoing seminars and lectures.
* Offering my honest perspective on the causes of your symptoms and discussing all reasonable options for diagnosis and treatment.
* Considering the complex relationships within your body, with the goal of improving function, reducing symptoms, and promoting overall wellness.
* Addressing disease prevention (such as heart disease and cancer) if that is one of your stated priorities.
* Exploring lifestyle-based interventions along with other appropriate treatments that may support your well-being.
* Providing a cost estimate at your initial visit (or upon request) so you know what to expect.
* Ensuring that the front desk, with my input, prepares an invoice that includes diagnosis and procedure codes for you to submit to your insurance provider.

**As a Patient, I Agree To:**

* Understand that my body is unique and may respond to treatments in individual ways.
* Treat my provider and all staff members with kindness, respect, and clear communication.
* Work with my provider as part of a team, committed to improving my health and overall well-being.
* Take responsibility for my attitude and mindset, and actively work toward improving my physical, emotional, and financial health.
* Let the office know how I prefer to be communicated with and share suggestions that may improve communication.
* Arrive on time for all appointments and understand:
  + Arriving more than **15 minutes late** may be considered a **no-show**.
  + Appointments that run **over the scheduled time** may incur **additional fees after 10 minutes**.
* Communicate my goals and priorities for each visit, as well as any long-term health goals when applicable.
* Provide feedback about how my care is going, and let the office know if something could be improved.
* Notify my provider if I experience any side effects or difficulties with my care plan.
* Do my part with “health homework” (e.g., exercises, supplements, dietary changes, lab work) to the best of my ability, and let the office know if something isn’t working.
* Speak up if I disagree with any recommendation—whether that be a test, exam, medication, or supplement—during or after my visit (via phone, email, or fax).
* Have another medical provider available in case of emergencies when my primary provider is unavailable.
* Call the office if I am running late or need to miss an appointment.
* Understand and respect the office policy that:
  + Cancellations or rescheduling require at least **48 hours’ notice** to avoid cancellation fees.
  + **All appointments are non-refundable.**
* Take responsibility for scheduling my own appointments and following through with the care plan I’ve committed to.
* Acknowledge that I have the right to choose the kind of care I feel is best for me. I understand that even if services are not covered (or only partially reimbursed) by insurance, I can still choose to invest in my healthcare.
* Recognize that investing in my health now can yield long-term benefits—both for my well-being and potentially for my finances.

**\*Acknowledgment**

I have read the information above and agree to participate in this care partnership with Water’s Edge Clinic. I understand I may request clarification or discuss any part of this agreement if needed.

**Patient Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*HIPAA NOTICE OF PRIVACY PRACTICES**

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

**We are required by law to:**

* Make sure that health information that identifies you is kept private
* Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
* Follow the term of the Notice that is currently in effect

**How we may use and disclose health information about you:**

* For treatment
* For payment
* For health care operations
* For appointment reminders
* As required by law
* To avert a serious threat to health and safety
* As required by the Military of Veterans and Workers
* Public Health risks
* Health oversight activities
* Lawsuits and disputes
* Law enforcement
* Coroners, health examiners, and funeral directors
* National Security and Intelligence activities
* Protective Services for the President and others
* Security Officials for Inmate

**Your rights regarding health information about you:**

* Right to inspect and copy
* Right to amend
* Right to an accounting of disclosures
* Right to request restrictions
* Right to request confidential communications
* Right to a paper copy of this notice

**Complaints:**

If you believe your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing.

**\*Acknowledgements of receipt of this Notice:**

We will request that you sign on a separate form acknowledging you have received a copy of this notice. The acknowledgement will become a part of your records

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),

I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
* Obtain payment from third party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *HIPAA Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *HIPAA Notice of Privacy* Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *HIPAA Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**RECORDS RELEASE AUTHORIZATION**

I hereby authorize: WATER’S EDGE NATURAL MEDICINE To release the following confidential medical information from the health record of Name/Date of Birth:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Copy of complete health record From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Lab results (specify)

\_\_\_\_\_X-Ray reports/film (specify)

\_\_\_\_\_Other (specify)

Information is to be released to (self or other):

Paper copies of medical records may be released upon receipt of written authorization of patients over the age of 18 or a legal guardian. Once authorization is received, it may take *up to 10 business days* to process your request.

There is a charge to obtain copies of medical records. If requested for private use by patients or guardians:

* No charge to the patient when records are sent via fax.
* No charges for page count if 10 pages or less.
* $0.20 per page for 10 pages and over plus shipping/handling.

If the records are needed for continuing care, there is no charge to the patient when records are sent (via fax) directly to your *physician* or the *facility providing treatment*. If records are needed for treatment or for an appointment within the next 48-72 hours, physicians can request records by fax when you arrive in his/her office for treatment.

**This authorization is valid for 365 days from the date signed**. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I also understand that my records are protected under the federal and state confidentially regulations and cannot be disclosed without my written consent otherwise provided for in the regulations.

**Patient/Guardians Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NOTE: Records containing information in relation to drug, alcohol, mental health and sexually transmitted diseases testing, diagnosis and treatment require a SPECIAL AUTHORIZATION.

**General Guidelines for Using the Patient Portal**

**Thank you for using our Patient Portal. Please review the following guidelines to ensure the best communication and care experience.**

**Messaging Your Health Care Provider**

* Please do not use the portal for medical questions or concerns.  
  The portal messaging system is not optimized for direct communication with your provider. For medical concerns or questions, please call our office at (206) 283-1383.
* Response Time:  
  Allow up to 48 business hours for a response. If your concern is new or more urgent, an appointment may be necessary to ensure appropriate care.
* After-Hours Urgent Medical Advice:  
  Call (206) 283-1383 and press option 3.

Please Note: There is an **$80 fee** for this after-hours physician service.  
For non-urgent concerns, please call during regular business hours to schedule an appointment.

**Prescription & Supplement Refills**

* Prescription Medications:  
  Contact your pharmacy directly to request a refill. Your pharmacy will fax the request to us at (206) 283-1924.

Please allow 2 business days for processing after your pharmacy sends the request.

* Supplement Orders:  
  Email your request to: Reminders@naturoapthic.com

**Lab Results, Treatment Plans, and Medical Records**

* Medical Records Release:  
  Records will be uploaded to the portal by request only. Please request records at least 7–10 business days before a scheduled appointment.

Ensure your records release form is current. Contact the front desk to complete or update the form.

**Sending Medical Records to Us**: You may upload and send medical records to us through the patient portal.

**Appointment Reminders**

* Text or Email Reminders:  
  To receive reminders via text or email, please confirm your mobile number and email address with the front desk.
* Phone Call Reminders:  
  If you prefer a phone call instead of digital reminders, please let the front desk know. We’ll opt you out of text and email reminders accordingly.

If you have any questions about using the portal or need assistance, please contact our front office at

(206) 283-1383.