Registration Form

PLEASE PRINT						Appointment Date:				
PATIENT INFORMATION										
Patient's last name:		First:	Middle:	Mr. Mrs.	Miss Ms.	Marital status: Please circle Single Mar Div Sep Wid Other				
Is this your legal name?		If not, what is your legal name?	(Former name):			Birth date:	Age:	Sex:		
Yes	No							M	F	
Street address:				Social Security no.:		Home phone no.:	Cell phone no.			
P.O. box:		City:				State:	ZIP Code:			
Occupation:		Employer:				Employer phone no.:				
Chose clinic because/referred to clinic by (Please circle)				Insurance plan	Yellow Pages	Friend/Family	Close to home/work			
Dr. (please give name):										
Other family members seen here:										
INSURANCE INFORMATION										
(Please give your insurance card and driver's license to the receptionist.)										
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:				
Is this person a patient here?	Yes	No								
Occupation:	Employer:		Employer address:			Employer phone no.:				
Is this patient covered by insurance?	Yes	No								
Name of primary insurance										
Subscriber's name:			SSN:			Birth date:	Co-payment: $			
Patient's relationship to subscriber:	Self	Spouse	Child	Other						
Name of secondary insurance (if applicable):										
Subscriber's name:			SSN:			Birth date:	Co-payment: $			
Patient's relationship to subscriber:	Self	Spouse	Child	Other						
IN CASE OF EMERGENCY										
Name of local friend or relative (not living at same address):			Relationship to patient:			Home phone no.:	Work/Cell phone no.:			

I consent to treatment necessary for the care of the above named patient. I authorize Dr. Kennedy to release or obtain all medical records to referring and family physicians, pharmacies and to my insurance company, if applicable. I allow fax/electronic transmittal of my medical records, if necessary. We will bill your insurance company as a courtesy to you. It is your responsibility to see that they pay on time. I understand that Dr. Kennedy is not accepting Motor Vehicle Accidents or Labor & Industry claims without prior authorization from this office. We reserve the right to either cancel or reschedule your appointment if prior authorization is not obtained. I understand that any balance considered patient responsibility is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Sheila Z. Kennedy, D.O. I hereby authorize the subscriber of the insurance, if not the patient, to speak with a representative of Sheila Z. Kennedy, D.O., regarding any balances owed by myself or to coordinate payment with my insurance company. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. I have read the privacy policy and understand my rights. *The Privacy Policy can be printed from the main menu.*

Patient/Guardian signature		*Date*	

HISTORY

Patient Name: **Age:** **Appointment Date:**

What do you do all day? *(i.e., sit at a desk, clear the back forty?*

Marital Status: ☐**Single** ☐**Married** ☐**Widow** ☐**Divorced** ☐**Separated** ☐**Life Partner**

How did you find our office?

Reason for your visit today, and what you wish to accomplish.

Childhood Illness' *(Check all that apply)* ☐**Measles** ☐**Mumps** ☐**Chickenpox** ☐**Rubella** ☐ **Rheumatic Fever** ☐**Polio** ☐**Other**

Last Tetanus Shot **Last Flu Shot** **HEP B Vaccine? Yes / No** **Pneumonia Vaccine Yes / No**

MEDICAL HISTORY/ROS: ***Check all that apply***	**Y**	**N**		**Y**	**N**
Rheumatoid Arthritis			Do you usually get up to urinate during the night?		
Fibromyalgia/Chronic Fatigue					
Joint / Muscle Pain			*If yes, number of times?*		
Osteoporosis			Do you feel pain or burning with urination?		
If yes, date of last bone scan:			Is there blood in your urine?		
Depression/Anxiety/Eating Disorders			Do you have a discharge from the penis?		
Learning Problems			Has the force of your urination decreased?		
Migraines/Stroke/Seizures			Have you had any kidney, bladder, or prostate infections within the last 12 months?		
Abuse, Sexual/Physical/Emotional					
Chronic Constipation/Diarrhea					
Have you had a colonoscopy?			Do you have any problems emptying your bladder completely?		
If yes, date Result					
Liver Disease / Hepatitis			Any difficulty with erection or ejaculation?		
Ulcers / Heartburn			Any testicle pain or swelling?		
Diabetes			Date of last testicular exam?		
Thyroid			Date of last prostate and rectal exam?		
Kidney Stones / Chronic Bladder Infections					
Sexually Transmitted Diseases					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Asthma					
Emphysema					
Frequent Upper Respiratory Infections					
Last Chest X-Ray? Date:					
Allergies					
Anemia					
Blood Clots					
Breast Disease					
Cancer- Type					

ALLERGIES/SENSITIVITES TO MEDICATIONS / REACTION (*i.e., hives, rash, shortness of breath, throat closing*)	**CURRENT MEDICATIONS** *(List all Prescriptions, Herbals, Vitamins and Over-The-Counter Medications you take*	
	Name of Medication	Strength

Sheila Z. Kennedy, D.O. Family Practice & Manipulation
820 Harvey Rd. Ste E Auburn, WA 98002
(253)939-1066 Fax: (253)939-1069

Name:

SURGICAL / HOSPITAL STAYS – *Please list all dates of surgeries or hospital stays, and the reason*		
Date	Surgery / Illness / Trauma	Why

SOCIAL HISTORY	Y	N
1. Do you currently, or have you in the past, used tobacco products? *If no, skip to question 2.*		
a. If yes, at what age did you start?		
b. What type of tobacco product do/did you use? ( )Cigarettes ( )Chew ( )Pipe ( )Cigars		
c. How much do/did you use on a daily basis?		
d. If you have quit, please give date:		
2. Do you drink alcohol? *If no, skip to question 3*		
a. Have you ever, or someone close to you, felt you should cut down on your drinking?		
b. Have people annoyed you by criticizing your drinking?		
c. Have you ever felt bad or guilty about your drinking?		
d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?		
3. Do you now, or have you in the past, used street drugs? *If no, skip to question 4.*		
a. If yes, at what age did you start?		
b. What type? c. How often?		
d. Did you, ever, even once, use a needle?		
4. Are you currently in recovery for alcohol / drug abuse? If yes, date:		
5. Do you drink caffeine? *Include coffee, tea, soda, etc.*		
a. Number of beverages a day?		
6. Do you exercise regularly?		
a. ( )at least 1-2x weekly for 30 min/day ( )3x weekly for 30 min/day ( )4x weekly for 30 min/day		
7. Are you currently dieting?		
a. Number of average meals you eat in a day?		
b. Do you snack? *If yes, what is your typical snack?*		
8. Do you live alone?		
9. Do you fall frequently, or accident prone?		
10. Do you wear contacts or glasses, or have vision problems? *i.e., color blindness*		
11. Do you have problems with your hearing, or wear a hearing aid?		
12. Do you have any tattoos? *If yes, what age or year did you get them*?		
13. Have you ever had a blood transfusion? *If yes, year:*		
14. Do you have an Advance Directive or Living Will?		
a. Would you like more information?		

For more information on Advance Directives or Living Wills, please visit our web site @ http://www.do-online/sheilazkennedy. Click on Links, then Washington State Department of Health, Living Wills.

FAMILY HISTORY

Is your Father still alive? ( )Yes ( )No If no, what did he die from? Age at Death?

Is your Mother still alive? ( )Yes ( )No If no, what did she die from? Age at Death?

	Who		Who
Cancer -Type		Stroke	
Breast		High Blood Pressure	
Uterine		High Cholesterol	
Prostate		Arthritis	
Lung		Osteoporosis	
Liver		Depression	
Other			
Diabetes			
Thyroid Disease			