

# REGISTRATION FORM

\*\*\* If the reason for this visit is work-related or a motor vehicle accident, let the receptionist know, so proper billing can take place! \*\*\*

## FINANCIALLY RESPONSIBLE PERSON (INSURANCE SUBSCRIBER)

Full Legal Name First \_\_\_\_\_ M/I \_\_\_\_\_ Last \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ APT# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Marital Status: M S W D Employer \_\_\_\_\_  
**Primary Insurance:** Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group# \_\_\_\_\_  
**Secondary Insurance:** Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group# \_\_\_\_\_

## SPOUSE

Full Legal Name First \_\_\_\_\_ M/I \_\_\_\_\_ Last \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ APT# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Marital Status: M S W D Employer \_\_\_\_\_  
**Primary Insurance:** Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group# \_\_\_\_\_  
**Secondary Insurance:** Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group# \_\_\_\_\_

## DEPENDENT CHILD(REN) UNDER 18 TO BE SEEN AT THIS CLINIC List additional children on back →

Child's Name First \_\_\_\_\_ M/I \_\_\_\_\_ Last \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex: M F Custodial Parent/Guardian \_\_\_\_\_ Phone# \_\_\_\_\_  
**Primary Insurance:** Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group# \_\_\_\_\_  
**Secondary Insurance:** Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group# \_\_\_\_\_



## EMERGENCY CONTACT (not living at same address):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

### Release of Benefits and Financial Information:

*I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for my claim(s).*

→ Signed: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## MARY'S FAMILY MEDICINE

16701 Cleveland Street • Suite 210 • Redmond, WA 98052 • Phone (425) 883-8050 • Fax (425) 885-2058

**Mary's Family Medicine  
Dr. Gina Landicho-Wicks  
16701 Cleveland Street, Suite 210  
Redmond, WA 98052**

**NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT**

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my Protected Health Information.

Today's Date: \_\_\_\_\_

Patient Name (please print): \_\_\_\_\_

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

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

Do you want a specific person to be able to talk to us, receive test results/phone calls, and make/cancel appointments for/about you? If yes, fill-out this next section:

**AUTHORIZATION TO ACCESS PROTECTED HEALTH INFORMATION**

I authorize \_\_\_\_\_ to have full access to my protected health information.

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

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

**Child Health Questionnaire**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Age \_\_\_ Male \_\_\_ Female \_\_\_ Grade in School \_\_\_\_\_ Religion \_\_\_\_\_  
 Previous M.D. \_\_\_\_\_ Location \_\_\_\_\_

Past, Ongoing or Recurrent Medical Problems		Past Surgeries/Hospitalizations	
Diagnosis	Year	Diagnosis	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications			
Medication	Dose(strength)	Frequency	Reason Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Nutritional/Herbal Supplements: \_\_\_\_\_  
 Other Treatments: (Please circle all that apply) Naturopathy, Chiropractic, Midwifery, Acupuncture, Others, For Example: Chinese Medicine, Curandero, Herbs etc... \_\_\_\_\_

Medication Reactions/Allergies (please include creams, pills, injections, drops, latex, iodine etc..)			
Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations			Past Infections			Past Exams		
	Y/N	Year		Y/N	Year		Y/N	Year
Standard childhood	___/___	_____	Chickenpox	___/___	_____	Eye Exam	___/___	_____
Influenza	___/___	_____	Tuberculosis	___/___	_____	Hearing Exam	___/___	_____
Hepatitis A (food borne)	___/___	_____	Rheumatic fever	___/___	_____	Speech Eval	___/___	_____
Hepatitis B (blood borne)	___/___	_____	Hepatitis	___/___	_____	Pelvic/PAP	___/___	_____
Tetanus (last)	___/___	_____	Pneumonia	___/___	_____			
Pneumonia	___/___	_____	Pelvic infection	___/___	_____			
MMR(Measles,Mumps,Rubella)	___/___	_____						

Girls: Menstruation? Y\_\_\_/N\_\_\_ Age at first period: \_\_\_\_\_

Family History of Diseases

Immediate Family (Please  below if any blood relatives have had the following problems: Mother-M, Father-F, Sister-S, Brother-B, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U, Cousin-C)

Age	Disease (if any)	Diabetes Y_/N_	Relation:___	Heart disease Y_/N_	Relation:___
Father _____	_____	Stroke Y_/N_	Relation:___	Hypertension Y_/N_	Relation:___
Mother _____	_____	Cancer Y_/N_	Relation:___	Tuberculosis Y_/N_	Relation:___
Bro/Sis _____	_____	Epilepsy Y_/N_	Relation:___	Arthritis Y_/N_	Relation:___
Bro/Sis _____	_____	Thyroid Y_/N_	Relation:___	Alcoholism Y_/N_	Relation:___
Bro/Sis _____	_____	Bleeding Y_/N_	Relation:___	Colon cancer Y_/N_	Relation:___
Bro/Sis _____	_____	Kidney Y_/N_	Relation:___	Mental illness Y_/N_	Relation:___
Bro/Sis _____	_____	Other: _____			

**Social History:** (Please check all that apply)

**Lives With:**  
 Father  
 Mother  
 Stepfather  
 Stepmother  
 Brother(s) how many? \_\_\_\_  
 Sister(s) how many? \_\_\_\_  
 Grandparents  
 Guardian  
 Other Adults \_\_\_\_\_  
 Other Children \_\_\_\_\_  
 If divorced/separated do the parents share custody of the child?

**Development:**

Delay in learning, walking, talking or speech? If known, please state \_\_\_\_\_  
 Attending school at expected grade level? If not, please state \_\_\_\_\_  
 Grades in School? \_\_\_\_\_ better average lower  
 Other Interests: \_\_\_\_\_  
 Is the child's diet high \_\_, moderate \_\_ or low \_\_ in fat?

**Child has been:**

Exposed to household member(s) smoking inside \_\_/outside \_\_  
 Exposed to alcoholism/drug abuse in household member(s)  
 Exposed to lead (paint older than 1960, gas stations, remodeling, adult in construction/welding)  
 Consuming caffeinated products, (chocolate, cola drinks, coffee, tea, caffeine pills)  
 Traveling outside the US? If so please state where \_\_\_\_\_  
 Sniffing glue or other products

**Birth:**

Were there problems in the mother's pregnancy? Y \_\_ N \_\_ Please state \_\_\_\_\_  
 Was the child's birth normal \_\_ or did complications occur \_\_, ? If so please specify \_\_\_\_\_

**Safety:**

Does the child use a car seat , booster seat or seat belt at all times? Y \_\_ N \_\_  
 While biking or on a scooter does the child use a helmet? Y \_\_ N \_\_  N/A  
 Does the child cross the street properly? Y \_\_ N \_\_  N/A  
 Have you talked to your child about strangers? Y \_\_ N \_\_ If so, at what age? \_\_\_\_  
 Has your child been involved in a serious or traumatic accident? If so, please state \_\_\_\_\_

**Systems Review:** Have you been bothered a significant amount by any of the problems below presently  or in the past (X)?

(Please mark all that apply:  present or ongoing problems, or (X) for PAST problems)

<b>General:</b>		<b>Heart:</b>		<b>Nervous System:</b>	
Constant fatigue	Y_/N_	Shortness of breath	Y_/N_	Convulsions	Y_/N_
Anemia	Y_/N_	Chest pain	Y_/N_	Fainting spells	Y_/N_
<b>Eyes:</b>		Palpitations	Y_/N_	<b>Genital:</b>	
Decreased vision	Y_/N_	Murmur	Y_/N_	Sexual diseases	Y_/N_
Glasses/Contacts	Y_/N_	<b>Lungs:</b>		Vaginal/penile discharge	Y_/N_
Glaucoma	Y_/N_	Wheezing/asthma	Y_/N_	Sexual problems	Y_/N_
<b>Ears:</b>		Chronic cough	Y_/N_	<b>Menstrual:</b>	
Hearing loss	Y_/N_	Coughing up blood	Y_/N_	Heavy/painful periods	Y_/N_
Recurrent ear infections	Y_/N_	<b>Stomach:</b>		Abnormal PAP smear	Y_/N_
Ringing in ears	Y_/N_	Frequent pain/heart burn	Y_/N_	<b>Mental Health:</b>	
<b>Head:</b>		Recurrent diarrhea	Y_/N_	Excessive worry/anxiety	Y_/N_
Frequent headaches	Y_/N_	Blood in stool	Y_/N_	Excessive moodiness/depression	Y_/N_
Dizziness	Y_/N_	Hemorrhoids	Y_/N_	Alcohol/chemical dependence	Y_/N_
<b>Nose/Throat:</b>		<b>Urinary:</b>		<b>Other: (please list)</b>	
Hayfever	Y_/N_	Decreased flow or control	Y_/N_	_____	
Recurrent sinus infections	Y_/N_	Painful/ frequent urination	Y_/N_	_____	
Severe snoring	Y_/N_	Blood in urine	Y_/N_	_____	
<b>Skin:</b>		Kidney stones	Y_/N_		
Changing moles	Y_/N_	<b>Musculo-Skeletal:</b>			
Chronic rash	Y_/N_	Joint pain or swelling	Y_/N_		
Skin growths	Y_/N_	Arthritis/gout	Y_/N_		

Additional questions for the doctor (may need to be answered at a separate visit, depending on complexity):

\_\_\_\_\_

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

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

FOR INFORMATION ONLY - NOT A STATEMENT OF AGREEMENT

INFORMED CONSENT REGARDING NATURAL FAMILY PLANNING  
At Mary's Family Medicine

As a matter of office policy, Mary's Family Medicine provides Family Planning advice and referrals only from the Natural Family Planning perspective.

Washington State Law mandates unrestricted access to all forms of contraception—natural and artificial, and access to abortions. Patients may have access to artificial means of birth control and abortions by seeing any of the other doctors, nurse practitioners, physician assistants or clinics in the area. Examples of artificial birth control includes pills, patch, vaginal ring, depo shot, IUD, diaphragm, cervical cap, condoms, Norplant inserts, morning-after pill, vasectomy, tubal ligation, and others. Access to contraception is confidential, and does not require a parent or guardian's consent. See 2003 list below.

By signing this form, I acknowledge that I am aware of the policy above, that I can seek care for myself from other sources, and that I can have a copy of this now, and in the future.

_____	_____	self / parent / guardian (circle one)
Signature	date	
_____	_____	self / parent / guardian (circle one)
Signature	date	
_____	_____	self / parent / guardian (circle one)
Signature	date	

**Natural Family Planning Resources:**

Billings Ovulation Method: (206)794-6173; (206)275-4266  
Couple to Couple: (425)788-2453

**2003 NEIGHBORING SOURCES OF HEALTH CARE**

**Family Practice** (check with insurance whether referral needed)

Individual solo doctors in Eastside with whom I share on-call: 644-2808; 391-8645; 222-7313; 391-3737

Family Medicine of Redmond: 881-8813

Evergreen Medical Group Redmond: 882-5020

Community Health Centers of King County, Redmond: 882-1697

Eastgate Public Health Center, Bellevue: (206)296-9770

**OB/GYN** (no referral needed for women's health services if your insurance is based on Washington State by virtue of Women's Health Care law)

Bellevue: 454-3366; 455-0244; 454-5758; 455-8888; 232-5400

Kirkland: 899-4444; 899-4455; 899-6400; 899-3888; 825-7898; 899-4000

**Urology** (may need referral depending on insurance)

Bellevue: 454-8016

Kirkland: 899-5800

MARY'S FAMILY MEDICINE  
16701 Cleveland Street, Suite 210  
Redmond, WA 98052  
Phone: (425) 883-8050 Fax: (425) 885-2058

**Privacy Officer: Gina Landicho-Wicks, MD**

**Effective Date: May 1, 2003**

**NOTICE OF PRIVACY PRACTICES**

*This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice at: (425) 883-8050.

**Who will follow this notice?**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except when treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

**How we may use and disclose Medical Information about you...**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other uses or disclosures that can be made without your consent or authorization:**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- In response to a legal proceeding
- Coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- Other public health activities
- As required by the US Food and Drug Administration (FDA)
- Other covered entities' and providers' payment activities
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Other healthcare providers' treatment activities
- To workers' compensation or similar programs for processing of claim

Please note: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION  
REQUIRING YOUR WRITTEN AUTHORIZATION:**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorizations, and that we are required to retain our records of the care we have provided you.

**YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION:**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

**Right to request confidential communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period from which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

**CHANGES TO THIS NOTICE:**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.