

# FORMA DE REGISTRO

\*\*\* Si la razón de su visita es relacionada con el trabajo o accidente de auto. Dígale a la recepcionista, así su cuenta sera hecha correctamente! \*\*\*

## PERSONA RESPONSIBLE FINANCIERAMENTE (INSCRITO AL SEGURO)

Nombre Legal Primer Nombre \_\_\_\_\_ M/I \_\_\_\_\_ Apellido \_\_\_\_\_

Seguro Social # \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Sexo: Masculino \_\_\_\_\_ Femenino \_\_\_\_\_

Dirección: \_\_\_\_\_ APT# \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado \_\_\_\_\_  
 Código Postal \_\_\_\_\_  
 Teléfono Casa# \_\_\_\_\_ Trabajo # \_\_\_\_\_ Célular # \_\_\_\_\_

Estado Marital: Casado \_\_\_ Soltero \_\_\_ Viudo \_\_\_ Divorciado \_\_\_ Empleador \_\_\_\_\_

**Seguro Primario:** Nombre del Inscrito: \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Compañía de Seguro \_\_\_\_\_ Suscriptor # \_\_\_\_\_ Grupo# \_\_\_\_\_

**Seguro Secundario:** Nombre del Inscrito \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Compañía de Seguro \_\_\_\_\_ Suscriptor # \_\_\_\_\_ Grupo# \_\_\_\_\_

## ESPOSO/ESPOSA

Nombre Legar. Primer Nombre \_\_\_\_\_ M/I \_\_\_\_\_ Apellido \_\_\_\_\_

Seguro Social # \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Sexo: Masculino \_\_\_\_\_ Femenino \_\_\_\_\_

Dirección: \_\_\_\_\_ APT# \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado \_\_\_\_\_  
 Código Postal \_\_\_\_\_  
 Teléfono Casa# \_\_\_\_\_ Trabajo # \_\_\_\_\_ Célular# \_\_\_\_\_

Estado Marital: Casado \_\_\_ Soltero \_\_\_ Viudo \_\_\_ Divorciado \_\_\_ Empleador \_\_\_\_\_

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## HIJO (S) DEPENDIENTES MENORES DE 18 QUE SERAN ATENDIDOS EN ESTA CLINICA

Lista adicional para niños en la parte de atrás →

Nombre del Niño: Primer \_\_\_\_\_ M/I \_\_\_\_\_ Apellido \_\_\_\_\_

Fecha de Nacimiento \_\_\_\_\_ Sexo: Masculino \_\_\_\_\_ Femenino \_\_\_\_\_ Padre/Guardián \_\_\_\_\_  
 Teléfono# \_\_\_\_\_

**Seguro Primario:** Nombre del Inscrito: \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Compañía de Seguro \_\_\_\_\_ Suscriptor # \_\_\_\_\_ Grupo# \_\_\_\_\_

**Seguro Secundario:** Nombre del Inscrito \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Compañía de Seguro \_\_\_\_\_ Suscriptor # \_\_\_\_\_ Grupo# \_\_\_\_\_

## PERSONA A LLAMAR EN CASO DE EMERGENCIA (Amigo o familiar que no viva con usted):

Nombre \_\_\_\_\_ Relación \_\_\_\_\_ Teléfono # \_\_\_\_\_  
 Referido a ésta oficina por: \_\_\_\_\_

### Permiso de Acceso a Beneficios e información Financiera:

Yo autorizo que los beneficios de mi seguro sean pagados directamente al doctor. Soy responsable financiero por el resto de la cuenta. Autorizo al doctor o a la compañía de Seguro a sacar cualquier información requerida para mi cuenta(s).

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

## MARY'S FAMILY MEDICINE

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



# SALUD DE ADULTOS (continuada)

## HISTORIA DE LAS ENFERMEDADES DE FAMILIA

Familia Inmediata			Marque debajo si cualquiera de sus familiares han tenido los problemas siguientes: (Abuela=grandmother=GM, Abuelo=grandfather=GF, TIA=A=aunt, TIO=U=uncle, primo=cousin=C)		
	Edad	Enfermedad			
Padre	_____	_____	diabetes si ___/no___ relacion _____	problemas del corazon	si ___/no___ relacion _____
Madre	_____	_____	embolio si ___/no___ relacion _____	alta presion	si ___/no___ relacion _____
Hermano/A	_____	_____	cancer si ___/no___ relacion _____	tuberculosis	si ___/no___ relacion _____
/	_____	_____	convulsions si ___/no___ relacion _____	arthritis	si ___/no___ relacion _____
/	_____	_____	tiroidea si ___/no___ relacion _____	alcoholismo	si ___/no___ relacion _____
/	_____	_____	sangrando si ___/no___ relacion _____	cancer del colon	si ___/no___ relacion _____
/	_____	_____	rinones si ___/no___ relacion _____	problemas mentales	si ___/no___ relacion _____

## HISTORIA SOCIAL

?Cuantos hijos/hijas? \_\_\_\_ Metodo contraceptivo \_\_\_\_ Si fuma tobacco, # cigarillos/cigaros por dia \_\_\_\_ o por semana \_\_\_\_  
 Ejercicio- dias por semana \_\_\_\_ Cafeina (café, te, chocolate, gaseosa que tiene cola) - bebidas diarias \_\_\_\_ o por semana \_\_\_\_  
 Bebidas alcoholicas- diarias \_\_\_\_ o por semana \_\_\_\_ ?Considera a su dieta ahora \_\_\_\_ alto, \_\_\_\_ moderado, \_\_\_\_ rebajado en grasas?  
 ?Hay alguien que le haya pedido que REBAJE cuanto alcohol esta tomando? si \_\_\_/no\_\_\_ ?Se queda ENFADADO/A cuando alguien le discute cuanto esta tomando?  
 si \_\_\_/no\_\_\_ ?Se siente con CULPA que algo ha pasado mientras que usted estaba tomando alcohol? si \_\_\_/no\_\_\_ ?Tiene que tomar una bebida de alcohol al DESPERTAR  
 por la manana? si \_\_\_/no\_\_\_ ?Ha usado drogas en su vida? si \_\_\_/no\_\_\_ /cuando Y que \_\_\_\_\_

REPASO DE LOS SISTEMAS DEL CUERPO: ?Usted ha sido molestado/a significativamente por cualquier de los problemas siguientes ahora o en el pasado?  
 (Marque con un V los problemas ahora o problemas que continuan, marque X los problemas del pasado)

### GENERAL:

Fatiga constante

Anemia

### OJOS:

Vision rebajada

Gafas/lentes de contacto

Glaucoma

### OREJAS/OIDOS:

No oye bien

Infecciones del oido repetidas

Zumbido en las orejas

### CABEZA:

Dolor de cabeza frecuentes

Mareo

### NARIZ/GARGANTA:

Alergias

Sinusitis repetidas

Roncando severo

### PIEL:

Lunar cambiando

Sarpullido cronico

Algo que crece en la piel

### CORAZON:

Respiracion corta

Dolor en el pecho

Palpitaciones

Murmuro/soplo

### PULMONES:

Piito/asma

Tos cronico

Tosiendo sangre

### INTESTINO/ESTOMAGO:

Dolores frecuentes o repetir/acidez

Diarrhea repetidas

Sangre en la excreta

Hemorroide/almorrana

### URINARIO:

Control o chorro rebajado

Orinando adolorido/frecuentemente

Sangre en la orina

Piedra en los rinones

### MUSCULAR/ESQUELETAL:

Coyuntura adolorida/hinchada

Arthritis, la gota

### SISTEMA NERVIOSO:

Convulsiones

Desmayos

### SEXUAL:

Enfermedades venereas

Flujo vaginal o por el pene

Problemas sexuales

### MENSTRUAL/MUJERES SOLO:

Periodos adoloridos o con muchisima sangre

Abnormalidad de la prueba de Papanicolau en el pasado

### SALUD MENTAL:

ansiedad o preocupaciones excesivas

depresion o melancolia o irritacion

dependencia en alcohol o drogas

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.

\_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_ self / parent / guardian  
(circle one)

\_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_ self / parent / guardian  
(circle one)

\_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_ self / parent / guardian  
(circle one)

**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

**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 and 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.

**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: \_\_\_\_\_