

* Helpful tips for your Doctor's visit *

- ❑ Please be aware that we do not accept HMO/Managed Care. If you have one of these plans, please call to cancel your appointment since we unfortunately will not be able to see you.
- ❑ Please arrive at least 20 minutes early to complete registration. Please allow adequate time for parking and traffic.
- ❑ Please be sure to bring your verifiable insurance card(s) and picture identification with you. Without these we will have to reschedule your appointment.
- ❑ Please be sure to fill out all of the enclosed paperwork. This will help the doctor and staff better assist you when you come.
- ❑ If you are concerned about your blood sugar or cholesterol and you would like to have your blood drawn on the day that we see you, please fast at least 12 hrs before your appointment (water, black coffee and tea are OK). You should take your medications but hold any diabetes medications.
- ❑ Please bring all medication bottles and medical records including lab results, studies and doctor's notes.
- ❑ If you have access to a fax, you can streamline your registration by faxing your forms to us in advance to 206-366-0907.
- ❑ Lastly, if you are going to be more than 10 minutes late from your scheduled time, please call us since we may need to reschedule your appointment.

**Please call us as soon as possible if you need to change
or cancel your appointment.**



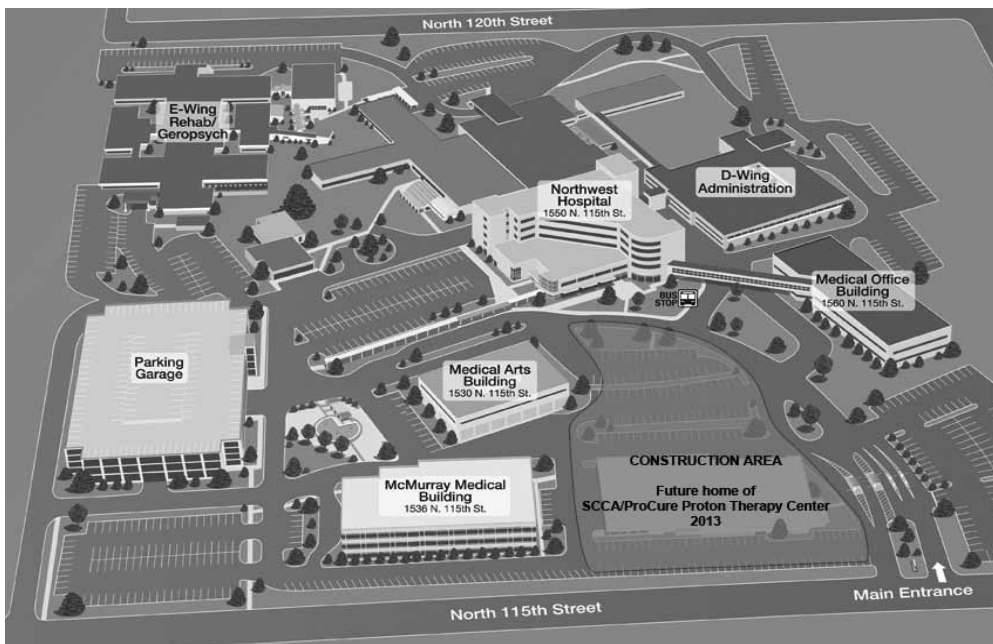
DIRECTIONS

Medical Arts Building
1530 N 115th St, Ste 104
Seattle, WA 98133

(206) 368-1311 ph | (206) 366-0907 fax

From I-5 (North or South)

- Take the Northgate Exit #173.
- Head West on Northgate Way (away from the Northgate Mall).
- Take a RIGHT at the light on Meridian.
- Take the first LEFT onto North 115th Street.
- Take a RIGHT into the main entrance to the Northwest Hospital & Medical Center Campus.
- We are the first building on the left as you drive in, directly across from the hospital drop off. We are in a gray, 3-story building with a sign out front labeled "Medical Arts Building."
- You may park in the parking garage or in the parking spaces. We do not validate parking. Limited 2 Hour street parking is available on North 115th St. Our office is located in Suite #104 which is on your RIGHT as you enter.



PATIENT REGISTRATION

Patient: _____ Mr. Miss Mrs. Ms.
Last First M.I.

Social Security #: _____ Birthdate: _____ / _____ / _____ Sex: M F
Month Day Year

Address: _____
Street City State Zip

Cell Ph: _____ Home Ph: _____ Work Ph: _____

Employer: _____ Phone: _____

Work Address: _____
Street City State Zip

Spouse: _____
Last First M.I.

Employer: _____ Phone: _____

Work Address: _____
Street City State Zip

IN CASE OF EMERGENCY FRIEND/RELATIVE TO CONTACT:

1. Name: _____ Phone: _____ Relationship: _____

2. Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

PRIMARY
Insurance Co. _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____
Policy ID #: _____
Group #: _____
Relationship to Patient: Self Spouse Child

SECONDARY
Insurance Co. _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____
Policy ID #: _____
Group #: _____
Relationship to Patient: Self Spouse Child

ASSIGNMENT AND RELEASE: I hereby authorized my insurance benefits to be paid to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release information required for this claim.

(All Patients Please Sign) Today's Date: _____

MEDICARE LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Dr. Michael Y. Lee for any services furnished me by that physician. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits payable for related services.

(All Medicare Patients Please Sign) Today's Date: _____

MICHAEL Y. LEE, MD

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):		Current or former occupation:		
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Previous doctor:		Date of last physical exam:		
Who can we thank for referring you to our office?				
Reasons for visit:				
1.				
2.				
3.				
PERSONAL HEALTH HISTORY				
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio				
Immunizations and dates:	<input type="checkbox"/> Tetanus (Td)	Date:	<input type="checkbox"/> Hepatitis A #1	Date:
	<input type="checkbox"/> Tetanus/Pertusis (Tdap)	Date:	<input type="checkbox"/> Hepatitis A #2	Date:
	<input type="checkbox"/> Influenza (Flu)	Date:	<input type="checkbox"/> Hepatitis B #1	Date:
	<input type="checkbox"/> Shingles	Date:	<input type="checkbox"/> Hepatitis B #2	Date:
	<input type="checkbox"/> Pneumonia	Date:	<input type="checkbox"/> Hepatitis B #3	Date:
	<input type="checkbox"/> Chickenpox	Date:		
Medical problems:				
Surgeries:				

Have you ever had a blood transfusion?

Yes No

Pharmacy		Phone	
Address	City	State	Zip

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> High	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	If you were giving you diet a grade, what would you give?			
	<input type="checkbox"/> A - Excellent	<input type="checkbox"/> B - Good	<input type="checkbox"/> C - Satisfactory	<input type="checkbox"/> D - Poor
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	How many drinks per week: _____ What kind: _____			
	Have you had a feeling of guilt or remorse after drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has a friend or a family member ever told you about things you said or did while you were drinking that you could not remember?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you failed to do what was normally expected of you because of drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Have you used tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of years: _____ Year quit: _____			
	<input type="checkbox"/> Cigarettes - pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy, list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive, Living Will or POLST? (We would like a copy of these forms for your medical record.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather Paternal		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap exam: _____		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times:		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam: _____		

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Notice of Privacy Practice - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Please print patient name

Date

Patient or legally authorized signature

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

This form will be retained in your medical record.

Dr. Michael Y. Lee

1530 N 115th St, Ste 104

Seattle, WA 98133

(206) 368-1311 ph

(206) 366-0907 fax

AUTHORIZATION TO RELEASE INFORMATION

Name (Please Print): _____

Date of Birth: _____ **SSN:** _____

Information to be release from: Physician _____

Address				
Street		City	State	Zip
Phone		Fax:		

Information to be released to: Dr. Michael Y. Lee

Information to be released: _____ Complete medical record (no films please)

_____ Last two years of records (no films please)

_____ Other (please specify) _____ Labs _____ Films

Authorization: I understand that my records may contain information regarding the diagnosis of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. By my signature below I authorize this information to be released in its entirety unless otherwise indicated below.

EXCLUSIONS: _____ HIV/AIDS _____ Sexually Transmitted Diseases

_____ Drugs/Alcohol _____ Mental Illness/Psychiatric Treatment

I understand I do not have to sign the authorization in order to obtain health care benefits (treatment, payment, or enrollment). I understand I may amend or revoke this authorization in writing at any time. I have been furnished with a copy of the Notice of Privacy Practices for this office and may request a copy at any time. I understand this information may be utilized, maintained and/or re-disclosed by the recipient according to organizations policy and is subject to Privacy Laws.

This authorization will expire 90 days from the date signed unless otherwise specified.

SIGNATURE: _____ **DATE:** _____