TRUEcare Integrative Medicine PLLC
12006 98th Ave NE Ste 103
Kirkland, WA 98034
P: (425) 820 – 1643 | F: (425) 820 - 1645
www.truecareintegrative.com

Patient Registration and Billing Intake Form

Welcome to TRUEcare Integrative Medicine. Please download and complete the medical intake forms, patient registration, and patient consent forms before your appointment if possible. Please note that the patient intake forms are intended to provide a broad picture of current and historical health issues and is comprehensive. This may take up to 15 minutes to complete. Thank you for advocating for your optimal health. If you are unable to fill out the forms before your appointment, please plan to arrive at least 15 minutes prior your appointment to complete intake paperwork. Please bring your insurance cards to your appointment when you check in.
Blessings in health! - Dr. Evangelynn

Patient's Legal Name: _____ Nickname:_____

Date of Birth (DOB): _____ Age: _____

Mailing Address: _____ City/State/Zipcode: _____

Email Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

May we leave detailed Personal Health Information (PHI) at these phone number(s)? ☐ Yes ☐ No

CONSENT to Leave Voicemails? (Voicemail from your provider/ New Health Medical Center may contain your personal health information.)

CONSENT to E-mail communications? (E-mails are a non HIPPA compliant way to contact your provider at TRUEcare, therefore we utilize a patient portal system through Practice Fusion. But if you choose to, you may share PHI info via email.) ☐ Yes ☐ No

Employment Status: Occupation: _____
☐ Employed ☐ Full-time
☐ Part-time ☐ Student
☐ Unemployed ☐ Retired

Marital Status:
☐ Single ☐ Married ☐ Significant Other ☐ Divorced

Smoking Status
☐ Never Smoker ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker

How do you identify your gender?
☐ Male ☐ Female ☐ Other

Preferred pronoun(s) if any? _____

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Who is your current Primary Care Provider? (Name of provider and clinic.)
_____

Preferred Pharmacy Location?
_____

Insurance and billing information:

Are we billing insurance? If so, please provide as much information below as possible: ☐ Yes ☐ No

Primary Insurance Company:

ID Number: _____ Group Number: _____

Co-Pay Amount: _____

Subscriber Name and DOB if different. _____

Subscriber's relationship to patient: (Select One)

☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company:

ID Number: _____ Group Number: _____

Co-Pay Amount: _____

Subscriber Name and DOB if different. _____

Subscriber's relationship to patient: (Select One)

☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact: _____

Phone Number: _____ Relation: _____

How did you hear about TRUEcare Integrative Medicine? Referred by?
_____

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New Patient Medical Questionnaire

Please complete the following medical questionnaire to the best of your ability. Your thoroughness of your answers will help guide the best care and effective treatment to find the root cause of your health concern.

Patient Legal Name: _____ Patient DOB:_____

Please list your present health concerns in order of importance. Please note how long each symptom has been present.

_____
_____
_____
_____
_____

Allergies to Medications? (Please list drug and severity of reaction.)

_____

Allergies to Food or Environment? (Please list severity of reaction.)

_____

Current Medications and Doses:

Medication Name:	Dosing of Medication:

Current Supplements and Doses:

Supplement Name:	Dosing of Supplement:

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Past Medical & Surgical History: (List dates and procedures)

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, what was the hospitalization for? Year of hospitalization or surgery?

_____

Date of Last Physical Exam: _____

Date of Last Labwork: _____

Date of Last PAP (if applicable): _____

Family Medicine History:

Please list relative and condition. (i.e. MGM - Hypertension, Father - High Cholesterol)

Social/Lifestyle History:

Do you use any of the following? (If so please check box.)

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ Caffeine

Please describe use of any of the above. (Frequency, Amount, Type)

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How often have you taken antibiotics? _____

How often have you taken pain killers (Ibuprofen/Motrin, Tylenol) _____

Please describe what your typical diet looks like: _____

Do you have any food restrictions or allergies? _____

How often do you get movement in your day? Type of activity, days/week, duration of activity?

_____

_____

Do you have any children? If so please list their age(s) and year(s) of birth:

_____

Have you ever been touched in a way that made you uncomfortable or was harmful to you without your permission? ☐ Yes ☐ No

Have you ever been physically or emotionally abused? ☐ Yes ☐ No

Do you have concerns about abuse or violence in your life now? ☐ Yes ☐ No

How would you describe your overall health?

_____

_____

Please include any additional information about you or your health that you think is important for me to know.

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