New Client Registration

Chet Robachinski, MD
509 Olive Way, Suite 204
Seattle, WA 98101
206-328-8216, ext 303

Name:_____ Age:___Gender:___Preferred Pronoun___

Address:_____ Social Security #_____

_____ Date of Birth:_____

_____

Preferred Phone Number:_____ OK to leave message at that number Y N

Person Responsible for Bill: _____

Address: _____Phone:_____

Employer Information:

Employer:_____

Address: _____

Work phone:_____OK to call and leave message here Y N

Insurance Information:

Name of Insured:_____SS#_____DOB_____

Primary Insurance Company:_____

Address:_____

Subscriber or ID #:_____Group #:_____

Secondary Insurance Company:_____

Address:_____

Subscriber or ID #_____Group #:_____

continued

Family Medical History

	Age	Living		Illnesses or Cause of Death
Mother	_____	Y	N	_____
Father	_____	Y	N	_____
Siblings	_____	Y	N	_____
Children	_____	Y	N	_____

Medical History

What medication, if any are you currently taking?_____

_____

Have you ever had a history of any of the following? (please check appropriate box)

Head Injury [ ] Seizure [ ] Memory lapses [ ] High Blood Pressure [ ] Diabetes [ ]

Heart Attack or Heart problem [ ] Asthma [ ] HIV [ ] Thyroid problem [ ]

Allergic or toxic reaction to any medication [ ] if so, which? _____

Any other medical problem not listed? _____

Women: Are you pregnant? Y N Don't know Date of last menstrual period _____

Name of Primary Care Provider _____ Date of last physical_____

By whom were you referred to our office? _____

Current Therapist _____ Phone number_____

Emergency contact:

Person_____ Relationship _____

Contact Information _____

I have read the office policy and agree to its content [ ]

Signature:_____

continued