New Patient Registration Form

Today's Date:

Patient Information		
Name (First, MI, Last):		Date of Birth:
Address:		City, State, Zip:
Home Phone	Mobile Phone Would you like to receive text notifications? ☐ Yes ☐ No	Work Phone
Email address (please print clearly):		
Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email		
Race/Ethnicity:	Are you of Hispanic origin? ☐ Yes ☐ No	Is English your preferred language? ☐ Yes ☐ No , I prefer:
Occupation/Employer:	Marital Status:	
Emergency Contact (person not living with you):	Emergency Contact Phone Number:	
What problem are you here for today?		
Primary Care Physician:	Who referred you to our clinic?	
Name of Preferred Pharmacy:	Location:	

Family and Social History		
Do you use tobacco? ☐ No, never ☐ Former user ☐ Yes, currently Current/Former Users: Type:	Amount per day:	Number of Years:
Do you drink caffeinated beverages? ☐ No ☐ Yes	If yes, how many per day?	
Do you drink alcohol? ☐ No ☐ Yes	If yes, how many drinks per week?	
Do you have a special diet?		

Review Of Systems

Patient Name	Date Of Birth

Review Of Systems	Please check Yes or No to indicate whether you are **CURRENTLY EXPERIENCING** any of the following symptoms.

		YES	NO
GENERAL	Chills/fever	☐	☐
	Weight change	☐	☐
	Change in strength	☐	☐
	Night sweats	☐	☐
EYES	Vision changes	☐	☐
	Double vision	☐	☐
	Eye pain	☐	☐
EARS	Change in hearing	☐	☐
	Ringing in ears	☐	☐
	Bleeding	☐	☐
NOSE	Nosebleeds	☐	☐
	Runny nose	☐	☐
	Post nasal drip	☐	☐
	Blocked nostril	☐	☐
MOUTH	Bleeding gums	☐	☐
	Tooth problems	☐	☐
HEART	Chest pain	☐	☐
	Palpitations	☐	☐
MSK	Muscle aches	☐	☐
	Tingling/numbness	☐	☐
	Joint aches	☐	☐
	explain: _____		
SKIN	Rash/hives	☐	☐
	Itching	☐	☐

		YES	NO
RESPIRATORY	Cough	☐	☐
	Wheezing	☐	☐
	Coughing up blood	☐	☐
	Shortness of breath	☐	☐
HEAD	Dizziness	☐	☐
	Dizzy upon standing	☐	☐
NEURO	Weakness	☐	☐
	Tremor	☐	☐
	Seizures	☐	☐
	Confusion	☐	☐
ABDOMEN	Change in appetite	☐	☐
	Problems swallowing	☐	☐
	Abdominal pain	☐	☐
	Nausea and vomiting	☐	☐
OTHER	List any other symptoms:		

Medical History: Please indicate whether you have now (or have a history) of any of the following conditions or diseases. Please describe Yes answers below

Yes	No		Yes	No		Yes	No	
☐	☐	Allergy problems/therapy	☐	☐	Diabetes	☐	☐	Sleep Problems
☐	☐	High Blood Pressure	☐	☐	Hepatitis (list type)	☐	☐	Heart Attack
☐	☐	Thyroid problems	☐	☐	Bleeding Disorders	☐	☐	Breathing Problems
☐	☐	Neurological problems	☐	☐	Transfusions	☐	☐	HIV
☐	☐	Kidney Problems	☐	☐	Cancer (list type)	☐	☐	Blood Clots
☐	☐	Stomach/Intestinal Problems	☐	☐	Irregular Heartbeat	☐	☐	Chronic medical problem
Other:			Other:			Please describe:		

Patient Medication Form

Medication Record		
Medication Name	Dose/Strength/ Frequency	Reason for Taking

Please list any allergies below:

Please list any surgeries or hospitalizations:	Date

Please indicate whether anyone in your ***immediate family (parents, siblings)*** have any of the following conditionss. If yes, please indicate which relative and specify the type of problem.

Yes	No			Yes	No		
☐	☐	Hearing Problems	_____	☐	☐	Bleeding Disorders	_____
☐	☐	Allergy	_____	☐	☐	Heart Problems	_____
☐	☐	Diabetes	_____	☐	☐	Sinus Problems	_____
☐	☐	Cancer	_____	☐	☐	Thyroid Problems	_____
☐	☐	Anesthesia Problems	_____				

Northwest Sleep and Sinus/Krueger Aesthetics

Notice of Privacy Practices.

I hereby authorize treatment by Northwest Sleep and Sinus and/or Krueger Aesthetics. I understand that my health information is private and that my insurance carrier will require information in order to process claims for payment of services rendered by Dr. Krueger. I authorize the release of pertinent medical information to my insurance carrier(s). I authorize payments to be made directly to Dr. Krueger by my insurance carrier(s). We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also 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 office. 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***.

Disclosing Health Information

I hereby consent to Krueger Aesthetics and/or Northwest Sleep and Sinus using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Krueger Aesthetics and/or Northwest Sleep and Sinus using or disclosing my protected health information for treatment activities provided by another health care provider as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider of health care entity to conduct health care operations including quality assessment.

E-Mail Policy

To better serve our patients, our office encourages patients to communicate with our staff via electronic mail. Email should only be used for routine matters that do not require an immediate response. Should you require immediate attention, email is not appropriate. We strive to respond to all emails within one business day. If a response is not received within your expected time frame, please call our office at 425-341-4305. Krueger Aesthetics and Northwest Sleep and Sinus take precautions to ensure information transmitted and received via email is secure. Our office is not liable for improper disclosure of information or breaches of confidentiality caused by the patient (i.e. printing or forwarding email), third parties, or technical factors beyond the Practice's control. By signing below, you acknowledge that Krueger Aesthetics and Northwest Sleep and Sinus will make its best effort to minimize the risk of confidentiality breaches for factors within its control, but cannot guarantee that unencrypted information will not be intercepted, altered or read by an unintended recipient. Email is only appropriate for certain types of communication with our office. Specifically, email is useful for simple, nonurgent questions. You may be instructed to schedule an appointment to discuss your question. I understand that Krueger Aesthetics and Northwest Sleep and Sinus are not liable for information loss or delay, or for breaches of confidentiality due to technical factors beyond the Practice's control. I understand and agree to the above email communication policy.

Patient Signature: _____ Date: _____

Print Name: _____

Northwest Sleep and Sinus/Krueger Aesthetics Financial Policy:

Medicare Beneficiaries:

I request payment of authorized Medicare benefits for any services furnished by Northwest Sleep and Sinus and/or Krueger Aesthetics. I understand that I am responsible for any health insurance co-payment, deductible, co-insurance, and/or non-covered services. I will be notified in advance for services Medicare does not consider medically necessary and financial arrangements will be made should I choose to proceed with the procedure. Medicare may consider some services ordered by Dr. Krueger not to be medically necessary. I will be notified in advance for the cost of these services so that I can work with my doctor to make a choice.

Non-covered services

We attempt to inform patients when services may not be covered, however I understand that it is my responsibility to understand my own health care limitations. I understand that Northwest Sleep and Sinus and Krueger Aesthetics contract with health care service plans (i.e.: "HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, I accept full responsibility for all items or services which are determined by the health care service plans not to be covered.

Financial Waiver

In the event that I do not have insurance, my deductible has not been met, my insurance company does not pay in full or my insurance denies payment; I understand that I will be liable for all charges incurred. I understand that if I do not have any insurance charges will be due and payable at the time of service. In the event my account is in default and placed for collection I understand that I will be responsible for all reasonable costs of collection and attorney fees.

Fees

A $50 service fee will be applied to your account for any returned check. If a check is returned, we will only accept a credit/debit card for future payments. A $25 fee is assessed for completion of Disability forms or Family Medical Leave Act (FMLA) forms.

Payment Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree to pay my account in full within 30 days of receipt of notice of all balances due such as non-covered services, coinsurance, deductibles and co-payments not paid by my insurance company in addition to any fees charged to my account.

I have read the above Financial Policy, understand the agreement and has had an opportunity to ask questions. I accept this policy in full.

Patient Signature: _____ Date: _____

Print Name: _____