Patient Information #1

Date: _____ Acct: _____

Name: _____
Last First Middle Name

Address: _____

Cell phone: _____ - _____- _____ **Home phone**: _____ - _____- _____

Work phone: _____ - _____- _____ **Email Address**:_____

Gender: ☐ Male ☐ Female **Martial status**: ☐ Married ☐ Single/Divorced/Widowed

Date of Birth: ____ / _____ / _____ **Social Security #** _____ - _____ - _____

Emergency Contact: Name: _____

Phone number: _____Relationship: _____

Employer: Name: _____

Phone Number: _____

Referring Doctor: _____ **Phone number**: _____

Insurance

As a patient, you are responsible for determining whether your insurance plan covers Dr. Shin's services. You should call your insurance provider or check its website to determine whether you are eligible to obtain services from Dr. Shin through your plan.
You also should be aware that many insurance plans require your primary care physician to submit a written referral before they will pay for the services of specialists, such as Dr. Shin. You are responsible for making sure that the proper referral documentation is submitted prior to you visit.
We encourage you to contact your insurance company; this is the safest way to avoid an unwanted liability. You have every right to obtain an oral and/or written reply from your insurance provider – particularly given that you probably are paying for the coverage!

Release of Benefits and Information

I have read and I accept the conditions listed under the heading "Insurance." I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

Printed Name: _____ Date: _____

Signature: _____

(Revised 5/1/2020)

Patient Insurance #2

Primary Health Insurance Policy Information

Please complete the following section if your bill will be covered by a health insurance provider. Also, you also will be expected to show us your insurance card for this policy at the time of your first visit.

Insurance Company Name:
Insurance ID Number:
Insurance Group Number:
Insurance Address: _____ Number Street _____ City State Zip code
Your relationship to the Policy Holder: ☐ SELF ☐ SPOUSE ☐ CHILD
Policy Holder's Name:
Policy Holder's Date of Birth:

Secondary Health Insurance Policy Information

Please complete the following section if you have secondary health insurance that may be required to cover all or a portion of you bill. Also, you will be expected to show us your insurance care for this policy at the time of you first visit.

Insurance Company Name:
Insurance ID Number:
Insurance Group Number:
Insurance Address: _____ Number Street _____ City State Zip code
Your relationship to the Policy Holder: ☐ SELF ☐ SPOUSE ☐ CHILD
Policy Holder's Name:
Policy Holder's Date of Birth:

UNI Clinic

#3

4300 Talbot Road. S. #314
Renton, WA 98055
P (425) 228-7446 F (425) 277-4746

Chang B. Shin, M.D., Neurology

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see your records. You also may request a copy of your records. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so.

By my signature below, I acknowledge I have read and agree with this notice:

Patient or legally authorized individual signature _____

Printed Name _____

Date _____

With whom may we share your information, including financial account information?

Name_____Relationship_____

Name_____Relationship_____

(Rev. 1/1/2020)

UNI Clinic

#4

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Chang B. Shin, M.D., Neurology

POLICIES OF UNI CLINIC

We strive to provide excellent medical care to all of our patients; therefore, we have established several policies that will help us meet this goal in an effective and efficient manner. We ask that you review the following policies and indicate your willingness to comply with them by signing in the indicated space. We will provide you a copy of this agreement to keep upon request.

Scheduled Appointments

Appointment time at our clinic usually is scheduled far in advance; therefore, patients often should wait longer than desired for treatment. When we receive 24-hour advance notification that you will be unable to keep your appointment, we frequently are able to fill your slot. On the other hand, last-minute cancellations and "no shows" reduce our ability to meet patients' needs. Our policy is to provide one warning for late cancellations/"no shows" and to charge a $35 fee thereafter. Please be aware that most insurance companies will not cover this fee and that you are likely to be personally responsible for pay it.

No Prescription

Dr. Shin will not prescribe any medication.

Emergencies

Generally, your medical needs will be satisfied most effectively by calling during our regularly scheduled office hours or leaving a message on our answering machine. Emergencies are rare in our practice. Of course, you should call 911 for any life-threatening emergencies, but if you feel you must have immediate attention, please call 425-228-7446 and follow the instructions for contacting our answering service.

Agreement

By my signature below, I acknowledge I have read and agree with these policies.

Patient or legally authorized individual signature: _____

Date: _____ Printed Name: _____

(Rev. 7/1//2020)

Patient's Health Questionnaire #5

Name: _____ Date: _____

Have you ever received Acupuncture in the past? ☐ Yes ☐ No

Do you want to try acupuncture treatment? ☐ Yes ☐ No

What medications are you taking? Please list both prescription and "over the counter" medication.

1. _____ 2. _____
3._____ 4. _____
5. _____ 6. _____
7. _____ 8._____
9. _____ 10. _____

Please list your drug allergies:

_____ _____

Starting from birth, list all your serious illnesses, operations, and hospitalizations:

Year or Age	Problem / Operations
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you use tobacco? ☐ No ☐ Yes Packs per day _____ for _____ years

Do you drink alcohol? ☐ No ☐ Yes Amount per day _____ for _____ years

(Rev. 2/11/2022)

Immediate Family History #6

Father	☐ Living	☐ Deceased	Age _____	Cause of Death _____
Mother	☐ Living	☐ Deceased	Age _____	Cause of Death _____
Brother(s)	☐ Living	☐ Deceased	Age _____	Cause of Death _____
	☐ Living	☐ Deceased	Age _____	Cause of Death _____
Sister(s)	☐ Living	☐ Deceased	Age _____	Cause of Death _____
	☐ Living	☐ Deceased	Age _____	Cause of Death _____
Son(s)	☐ Living	☐ Deceased	Age _____	Cause of Death _____
	☐ Living	☐ Deceased	Age _____	Cause of Death _____
Daughter(s)	☐ Living	☐ Deceased	Age _____	Cause of Death _____
	☐ Living	☐ Deceased	Age _____	Cause of Death _____

Does anyone in your FAMILY (parents, siblings, grandparents, aunts, uncles, and children) have (or had in the past):

Yes	No		Yes	No	
___	___	Diabetes	___	___	Epilepsy
___	___	Migraines	___	___	High Blood Pressure
___	___	Heart Disease	___	___	Stroke
___	___	Cancer	___	___	Muscular Dystrophy
___	___	Muscular Atrophy	___	___	Mental Retardation
___	___	Other _____	___	___	Other _____
___	___	Other _____	___	___	Other _____

Please briefly describe the major conditions for which you are seeking treatment and provide information on prior treatments you have received for that condition.

Major Conditions	Prior Treatments	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had or do you now have? #7

Yes	No		Yes	No	
___	___	Loss of consciousness	___	___	Loss of smell
___	___	Loss of vision	___	___	Blindness in one eye
___	___	Double vision	___	___	Ringing in ears
___	___	Hearing loss	___	___	Trouble speaking
___	___	Stroke	___	___	Seizure or convulsion
___	___	Numbness or pins/needles	___	___	Meningitis
___	___	Memory loss	___	___	Change in personality
___	___	Great swings in mood	___	___	“Nervous breakdown”
___	___	Psychiatric consultation	___	___	Tranquilizer treatment
___	___	Nightmares	___	___	Insomnia
___	___	Snoring	___	___	Loss of appetite
___	___	Fatigue	___	___	Diabetes
___	___	Thyroid trouble	___	___	Menstrual trouble
___	___	Asthma	___	___	Emphysema
___	___	Tuberculosis	___	___	Liver disease
___	___	Ulcer	___	___	Blood in stool
___	___	Anemia	___	___	Bleeding problem
___	___	Heart attack	___	___	Tumor or growth
___	___	Rheumatic fever	___	___	Heart murmur
___	___	Racing heart	___	___	High blood pressure
___	___	Gonorrhea or syphilis	___	___	Kidney infection
___	___	Loss of bladder control	___	___	Blood in urine
___	___	Gout	___	___	Loss of bowel control
___	___	Exposure to chemicals	___	___	Arthritis
___	___	“Learning” or development problems	___	___	Other _____

PHQ-9 / GAD-7 #8

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

PHQ-9 Please use the ✓ to indicate answer.	Not at all	Some	Often	Nearly all of the time
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

TOTAL _____

GAD-7 Please use the ✓ to indicate answer.	Not at all	Some	Often	Nearly all of the time
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen soon	0	1	2	3

TOTAL _____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to; do your work, take care of things at home, or get along with people?

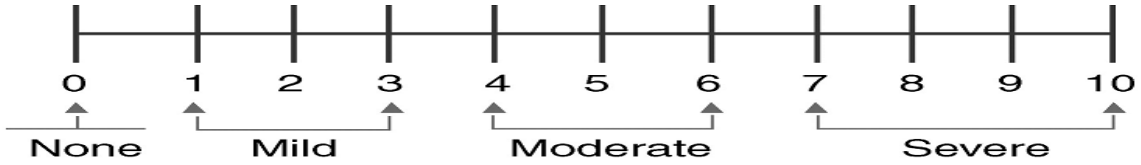
Not difficult at all	☐	**Somewhat difficult**	☐	**Very difficult**	☐	**Extremely difficult**	☐

(Rev. 1/1/2020)

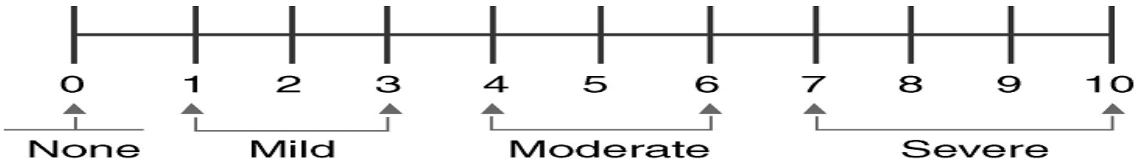
Patient Pain/Symptoms Report

Name:_____ Today's Date:_____

1. What is your pain level RIGHT NOW and AVERAGE? (Please write "N" for Now and "A" for Average)



2. What is your pain level at its BEST and WORST? (Please write "B" for Best and "W" for Worst)

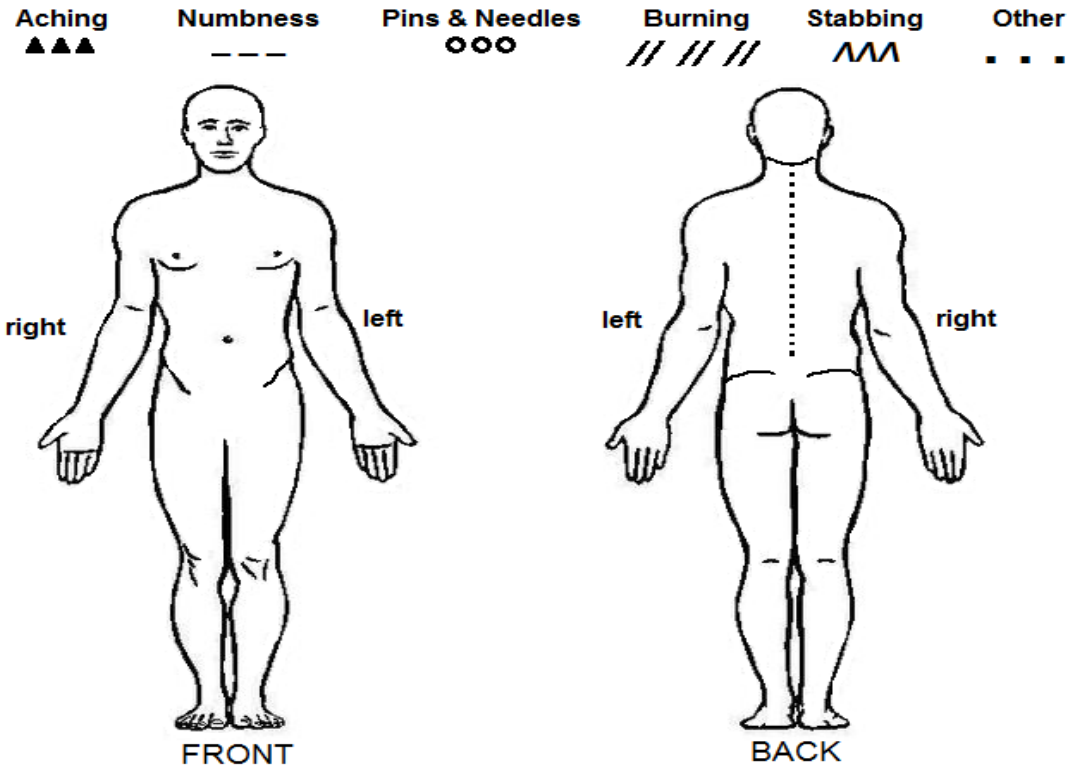


3. What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = "not at all," 10 = "complete interference") _____

4. What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY?

(0 = "not at all," 10 = "complete interference") _____

5. Using the symbols below, please MARK the areas on the drawings where you feel the described sensations.



6. Other medical complaints:_____

(Rev. 1/1/2020)