Creekside Center

for Integrative Medicine

Welcome to Creekside Center for Integrative Medicine, the Center that provides you with outstanding care by a group of independent practitioners.

Creekside Center is committed to provide you the highest quality services in a caring environment. Our practice includes a team of health professionals who treat acute and chronic medical problems. Our goal is to return you to a state of balance medically, nutritionally, and emotionally by incorporating changes into your life that are personally comfortable and satisfying.

Treatment may include a thorough medical examination, nutritional biochemical analysis, allergy testing, and lifestyle evaluation. Psychotherapy and counseling are available for issues related to stress, life transition, and emotional health. Physical therapy, and Acupuncture can relieve musculoskeletal problems, pain, and a great variety of other problems. We also offer Naturopathic medicine, Nutritional counseling, as well as evaluations for Sleep disorders. Our team of independent practitioners is dedicated to your health and wellbeing.

We are specialists in outpatient preventive medical care - *not emergency care*. In most cases, routine acute care can be handled in our office.
Dr. Markus is available off-hours through our 24-hour emergency paging system. If you need a physician for hospital admission, we have a referral network.

***Supplemental products, vitamin shots and are not covered by insurance. Payment is required at time of visit*.**

Please complete the enclosed forms and bring them with you at the time of your visit, or you may fax to our office at 425-641-2721. Because many of our clients are chemically sensitive, *PLEASE DO NOT WEAR FRAGRANCES WHEN YOU VISIT THE CENTER*.

We look forward to assisting you on the road to better health.

Stephen P. Markus MD
Medical Director

CREEKSIDE CENTER

Creekside Business Park|1540 140th Ave NE| suite 101|Bellevue, WA|98005
Phone 425 644 6048|fax 425 641 2721| www.creeksidemedicine.com

Patient Registration

Please Print

PATIENT ____

Last Name First Name M.I.

SEX ☐ Male ☐ Female

ADDRESS ______________________________

____

City State Zip

PHONE (HOME) ____________________ OK to leave message? Yes No

(CELL) ____________________ OK to leave message? Yes No

(WORK) ____________________ OK to leave message? Yes No

E-MAIL ______________________________

BIRTHDATE ______________________________

SSN ______________________________

EMPLOYER ______________________________

INSURANCE AND/OR INJURY INFORMATION

☐ Bill private insurance
☐ On-the-job injury
☐ Cash

EMERGENCY CONTACT

A LOCAL FRIEND OR RELATIVE TO BE NOTIFIED:
(NOT LIVING AT THE SAME ADDRESS)

NAME ________________________ RELATIONSHIP____________________

ADDRESS ________________________ PHONE (HOME)____________________

________________________ (CELL) ____________________

City State Zip

(WORK) ____________________

NEW PATIENT Information **Today's Date**:__________

Name:____ Male Female
FIRST MIDDLE LAST

Date of birth:____________________**Age**:________**Height**:________**Weight**:________

Home / cell phone: ___________________________________ OK to leave message? Yes No

Who referred you to this office?____

Current Problems (in order of priority) Not listed below:

1.____How Long?__________________
2.____How Long?__________________
3.____How Long?__________________
4.____How Long?__________________
5.____How Long?__________________
6.____How Long?__________________
7.____How Long?__________________

Please List Chronic Problems you have had for years, not listed above:

1.________________________________How Long?___________ Still Active? YES / NO
2.________________________________How Long?___________ Still Active? YES / NO
3.________________________________How Long?___________ Still Active? YES / NO
4.________________________________How Long?___________ Still Active? YES / NO

Family History:

	Father	Mother	Aunt/Uncle/GP	Siblings
Heart disease/ Cholesterol				
Hypertension				
Stroke				
Cancer (type)				
Cancer (type)				
Diabetes Insulin Yes /No?				
Thyroid disease				
Osteoporosis				
Mental Illness				
Allergies, Asthma, Hay fever				
Blood disorder, Anemia				
Arthritis, myofascial pain				
Other				

Patient Name: ________________________________**Date**:_____________________

Past Medical History:

Surgeries Inpatient or Outpatient:

1.____Year__________________
2.____Year__________________
3.____Year__________________
4.____Year__________________
5.____Year__________________

Hospitalizations (Include Pregnancies) Not listed above:

1.____Year __________________
2.____Year __________________
3.____Year __________________
4.____ Year _________________

Significant Illnesses Not listed above:

1.____ Year__________________
2.____ Year__________________
3.____ Year__________________
4.____ Year__________________

Habits:

1. **Smoking**: NO / YES _______packs per day, for ________________years.
2. **Alcohol**: NO / YES _____glasses, of wine, beer, mixed drink, per day /week / month.
3. **Exercise**: NO / YES
   - Aerobics______________ times, per week / month.
   - Weight Training ____________times, per week / month.
4. **Sleep**: Significant trouble falling asleep? NO / YES
   - How long does it take? ____Hours
   - Several awakenings during the night? NO / YES
   - Significant snoring? NO / YES
   - Have you been told that you stop breathing? NO / YES
   - Unreasonably early morning awakening? NO / YES
     What time? ______AM
   - Are you well rested in the morning? NO / YES.
   - Daytime sleepiness? NO / YES
   - Uncontrolled blood pressure? NO / YES.
   - Acid Reflux? NO / YES
   - Restless legs when falling asleep? NO / YES
   - Jerking or Kicking of legs? NO / YES
5. **Diet**: **Coffee** ___cups, per day. **Caffeinated Tea** ___ cups, per day. **Pop** ___cups per day.
6. **Stress Level** (average per week): 1 2 3 4 5 6 7 8 9 10
   (lowest) (highest)

Patient Name:____________________________ **Date**:_____________________

7. Please rate your meals on a 1 (poor quality) to 5 (excellent quality) scale:

Average per week: 1 (lowest) 2 3 4 5 (highest)

8. Please rate your sweets / chocolate intake on a 1 (negligible) to 5 (large quantity)

Average per week: 1 (lowest) 2 3 4 5 (highest)

9. Medication Allergies and Sensitivities: **Type of Reaction**

1.____ ___________________________
2.____ ___________________________
3.____ ___________________________
4.____ ___________________________

Have you ever had a serious allergic or an anaphylactic reaction? YES / NO

10. Non-Medication Allergies and Sensitivities:

1. Dog:_________ Cat:__________ Other animal:___________________________
2. Grass:_________ Tree:_________ Weed:_________ Allergy Tested? YES / NO
3. Dust: _________Mite:_________ Insects:_______________________________
4. Foods:____
5. Chemicals / Contact allergy:____

Please list your Current Medications only:

(Over the counter *Vitamin Supplements* on next page)

Name of drugs/ medicine	Reason for taking	Doses: milligrams or # of capsules	How many times per day or week	How long have been taking ?

Patient Name:______________________________ **Date**:____________________

Vitamins, herbs, and supplements you are taking now.

Name of herbs, vitamins, nutrients	Reason for taking	Doses	How many times per day or week	How long have you been taking ?

Patient Name:_______________________________ **Date**:_____________________

Please *Circle* any of the following problems that are not mentioned prior:

General: Recent weight gain or loss, fevers, night sweats

Other:

Head and Neck: Headaches, dizziness, fainting, hearing problems, vision problems, dental problems, sinus infections, colds, swallowing problems, swollen glands, allergies

Other:

Heart: Chest pain, palpitations, blood pressure, irregular heartbeat, swollen legs, murmur

Other:

Lungs: Cough, shortness of breath, asthma, frequent bronchitis or pneumonia, strep

Other:

Gastrointestinal: Constipation, diarrhea, irritable bowel, bright red blood in stool or hemorrhoid, change in color of stool, stomach burning or acid reflux, bloating or indigestion, mucous in stool, nausea or vomiting, hepatitis

Other:

Genital or urinary: Frequent urination, trouble with your stream, leaking of urine (with cough /exercise / can't get to the bathroom on time?), prostate infections, impotence, erectile dysfunction, hernias, trouble with orgasms, vaginal or testicular pain, frequent infections, bladder, kidney infections, blood in urine. Sexually transmitted disease

Other:

Muscular and Skeletal: Neck pain, spinal pain, low back pain, shoulder, elbow, wrist, hand pain, hip, knee, ankle, foot pain

Other:

Neurologic system: Pain, loss of sensation, or loss of function of arms, legs, tremors

Other:

Psychological: Feeling sad most of the time, crying, hopeless, trouble sleeping, poor appetite, significant weight changes, not interested in socializing or activities, tired all the time, lack of interest in sex, irritable, suicidal thoughts, poor concentration, anger

Major changes in your life: death, divorce, job, move or other:

Skin: Rashes, itching, infections, eczema, psoriasis, moles or lumps, bruising, hair loss

Hormone problems- thyroid, female, male, adrenal

Bleeding or bruising, anemia

Please elaborate on anything asked above:

____

____

PROCEDURES AND FINANCIAL POLICY
Between You and Stephen Markus MD

OFFICE HOURS- Our phones are open from 9:00 AM to 1:00 PM, and 2:00 PM to 5:00 PM Monday through Thursday, and from 9:00 AM to 2:00 PM on Friday. Our voice mail service will answer calls off hours and on weekends***. If there is ever an emergency, please call 911***

PRESCRIPTION REFILLS- Please call your pharmacy when you need a prescription refilled. If needed, they will call us for approval. This process can take up to **(2) business days** so try to anticipate your medication needs in advance of weekends and holidays.

MEDICAL RECORDS- All your records are confidential. **NO** information will be released (even to family) without your signed consent. If you authorize us to release information to others this process can take up to **(2) weeks.** Please review "Privacy Policy Notice" for a full disclosure of how we will manage your health information.

APPOINTMENTS- If your schedule changes and you will be late for an appointment, or cannot keep your appointment, **PLEASE CALL IN ADVANCE at 425-644-6048** so that another patient can be scheduled for your time. **We do charge a fee between $45 and $90 for missed appointments or appointments cancelled without 24 hours notice**.

ABOUT INSURANCE- We cannot guarantee that the information provided to you regarding insurance eligibility is correct. While in some cases we may provide you with our best knowledge of your insurance coverage as a courtesy, it is your primary responsibility to determine your eligibility status with your insurance company. If Dr. Markus provides service to you for which you are determined to not be eligible, then you are responsible to pay for those services.

FINANCIAL INFORMATION- Dr. Markus accepts Debit, Visa and Master Card, checks or you may pay by check and cash for your payment. Dr. Markus will bill your insurance directly, and any remaining balance is your responsibility. Any balance unpaid after **(60) days** will accrue a ***1.5% finance charge per month***. Balances not paid within **(90) days** must have appropriate financial arrangements made with our bookkeeper. Balance not paid after **(120) days** ***will be turned over to COLLECTION***. ***We charge a $35.00 fee for all returned checks, RCW62A.3 515520. Co-pays are due at time of service to avoid a $5.00 billing fee.***
PLEASE MAKE OUT YOUR CHECK TO **Stephen Markus MD** FOR OFFICE VISITS, AS WE ARE A CLINIC OF INDEPENDENT PRACTITIONERS.

SUPPLEMENTS- Creekside Center stocks vitamins, minerals, and herbal products for the convenience of our patients. You are under no obligation to purchase these products. ***WE WILL NOT BILL YOUR INSURANCE FOR SUPPLEMENTS.***

FRAGRANCES- Since many of our patients have chemical sensitivities**, and we do allergy testing here at the center*, please do not use fragrances when you visit the center. Thank you.***

PATIENT AGREEMENT

I understand and accept the terms of the above-described financial policy/disclosure apply to Stephen Markus MD. I understand I am individually responsible for payments of all charges. I have had an opportunity to view the **NOTICE OF PRIVACY PRACTICES**. I am aware that this Financial Policy and Privacy Policy may change, without notice.

Signature: ______________________________ Date: ______________________

Creekside Center for Integrative Medicine
1540 140th Ave. NE Suite 101 Bellevue, WA. 98005
A group of Independent Practitioners
425 644-6048

02/15/05