Western Washington
Medical Group

Gastroenterology

Dear Returning Patient:

APPOINTMENT SCHEDULED: ______________________ CHECK IN TIME: ______________________

WITH DOCTOR: ______________________ PHONE: **(425) 259-3122 (for all offices)**

EVERETT OFFICE
43rd & Hoyt Medical Bldg
4225 Hoyt Ave, Suite A
Everett

ENDOSCOPY CENTER
Providence Regional Mill Creek
12800 Bothell – Everett Hwy. # 200
(also known as 19th Ave SE or Hwy 527)
Everett

In order to update our records we have enclosed a packet of information and forms for you to read, fill out at your leisure at home, and **bring with you to your appointment**. We thank you in advance for taking the time to fill these forms out ahead of time. Here is a checklist of the forms that are enclosed and short explanation of each:

- Registration Form – please remember to also bring **all of your insurance cards**. We will need to scan a copy of the front and the back of the actual card(s). If **your insurance plan requires a copayment** we will collect it at the time of your visit. If your **insurance plan requires a referral** it is your responsibility to obtain one from your primary care physician, prior to this office visit. If you have difficulty obtaining the referral from your PCP please call our referral coordinator at (425) 259-3122, to see if she can assist you in any way.
- Medical History Form – it is extremely important to complete the form as fully as possible. This will enable us to care for you appropriately. If you require additional room, please write on a plain sheet of white paper and attach it to the History Form.
- Friends and Family Release - List the family members, friends, or caregivers that you wish to have access to your private healthcare information. We are required by law to have your signature on this verbal disclosure form.
- Directions and map to the office which is highlighted above. We regularly see patients at many different locations. Please be sure that you note the correct office location for your appointment.
- Please also bring an updated list of your current medications, including dosage and how often you take them. Also include herbal or over the counter medications and supplements too.

It is our hope that you will find this material informative, and that by completing these forms in advance of your appointment your time in our office will be better spent. Again, thank you for taking the time to have all of your forms ready when you arrive for your appointment. We look forward to participating in your medical care once again.

Western Washington Medical Group

DEPARTMENT OF GASTROENTEROLOGY/ENDOSCOPY

REGISTRATION FORM

ACCOUNT#________________ NEW _____ UPDATE ______

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME

DATE OF BIRTH	SEX M F	RACE ETHNICITY	SOCIAL SECURITY # PREFERRED LANGUAGE

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT
STREET ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT

HOME PHONE	WORK PHONE EXT	CELL PHONE
( )	( )	( )

REFERRING DOCTOR	MARITAL STATUS MARRIED _____ DIVORCED _____ OTHER _____
PRIMARY CARE DOCTOR	SINGLE _____ WIDOWED _____ SEPARATED _____
PHARMACY NAME, PHONE NUMBER AND LOCATION	PREFERRED EMAIL ADDRESS

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED_________ OR DISABLED________)

EMPLOYER NAME	OCCUPATION

STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

PRIMARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER	

SUBSCRIBERS DATE OF BIRTH	SUBSCRIBER'S SEX MALE ___ FEMALE ___	SUBSCRIBERS ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER	

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX MALE ___ FEMALE ___	SUBSCRIBERS ID #	GROUP NUMBER

EMERGENCY CONTACT (NOT LIVING WITH YOU)	NAME	RELATIONSHIP	PHONE NUMBER- HOME/WORK/CELL ( )

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ SELF (* If self do not fill in right field.)	SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI
_____ SPOUSE _____ PARENT	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT
_____ GUARDIAN	HOME PHONE ( )	WORK OR CELL PHONE EXT ( )	DATE OF BIRTH	SEX M F

WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

PATIENT SIGNATURE ______________________________ ***DATE***

For office use only
Dr.____________________ Ins. code_______________________ Acct # __________________________ Initials ______

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FINANCIAL AGREEMENT

We consider all patients as "**private**" unless their insurance is one with whom we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "**private**" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care. It is the patient's responsibility to check their benefits prior to being seen.
*Please be familiar with the benefits provided by your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If you're insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service, if you are unable to pay your co-pay at time of service there will be an **additional $15.00 fee** charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for principle payments and interest on the unpaid balance of 1% per month from the date of the service plus any collection fees, and reasonable attorney fees and court costs.

We charge $35.00 for any NSF checks. (per RCW 62A-3-515 & 520)

With my signature I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name______________________________DOB______________________

Signature_________________________________Date_______________________

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2013 FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary and appropriate. I understand that information is limited to verbal discussions and that **no paper copies of my Personal Healthcare Information (PHI) will be provided without my signature** to release information from my chart. I, the patient, may be asked to sign a Release of Record to release WWMG to share information if my provider and his/her designee deem it necessary.

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: ______________________ **Relationship:** ______________ **Phone:** ______________

Name: ______________________ **Relationship:** ______________ **Phone:** ______________

Name: ______________________ **Relationship:** ______________ **Phone:** ______________

Patient's Personal Phone Information : NOTE! This is DIFFERENT than the above info.

Please provide us with **YOUR *best, most current*** phone contact information. This information will become part of your permanent medical record *unless/until you change it*. You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First phone number: ______________________ Cell Work Home OK to leave detailed message: Y N

Second phone number: ______________________ Cell Work Home OK to leave detailed message: Y N

Third phone number: ______________________ Cell Work Home OK to leave detailed message: Y N

X ______________________ ______________________
PATIENT OR GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

X ______________________ ______________________
PRINTED name of person signing DATE

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(PLEASE USE BLACK INK)

CHANGES TO MEDICAL HISTORY FORM

Why are you here? ______________________________

What makes the problem better or worse? What medication have you tried?

____

____

Please give us an update on any changes to your health history since your last visit to our office.

SURGERIES ______________________________

ILLNESSES ______________________________

____

ALLERGIES ______________________________

CHANGE IN HABITS (i.e. smoking, alcohol etc.) ______________________________

____

CHANGE IN MEDICATIONS See medication list

If you are 50 years of age or older have you recently had a flexible sigmoidoscopy, or colonoscopy performed? Yes No

PATIENT NAME ______________________________ **DOB** ____________

PLEASE PRINT

____

PATIENT SIGNATURE

____

PHYSICIAN INITIALS **DATE**

****PLEASE COMPLETE THE BACK SIDE OF THIS FORM ****

PLEASE ANSWER ALL QUESTIONS

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE YEAR?

Check all the apply to you. If it does NOT apply to you please leave blank.

CONSTITUTIONAL

- [ ] Chills
- [ ] Night sweats
- [ ] Fever
- [ ] Fatigue
- [ ] Headaches
- [ ] Loss of appetite

EYES

- [ ] Eye pain
- [ ] Wear corrective lenses/contacts
- [ ] Blurred vision
- [ ] Sudden change in vision

ENT

- [ ] Loss of voice
- [ ] Laryngitis
- [ ] Hoarseness
- [ ] Hearing loss
- [ ] Mouth sores
- [ ] Bleeding gums

CARDIOVASCULAR

- [ ] Chest pains
- [ ] Palpitations
- [ ] Swelling of feet/ankles
- [ ] History of blood clots (DVT)
- [ ] Heart murmur

RESPIRATORY

- [ ] Frequent cough
- [ ] Shortness of breath
- [ ] Asthma/wheezing

GENITOURINARY

- [ ] Frequent urination
- [ ] Burning/painful urination
- [ ] Blood in urine
- [ ] Urinary hesitancy
- [ ] Anal intercourse
- [ ] Male prostate problems
- [ ] Female heavy periods
- [ ] irregular periods
- [ ] History of sexual abuse?

MUSCULOSKELETAL

- [ ] Joint pain
- [ ] Joint stiffness
- [ ] Joint swelling
- [ ] Muscle pain
- [ ] Muscle cramps
- [ ] Back pain

SKIN

- [ ] Rash
- [ ] Itching
- [ ] Change in moles?
- [ ] Tattoos

NEUROLOGICAL

- [ ] Head injury
- [ ] Convulsions/seizures
- [ ] Numbness or tingling sensation
- [ ] Tremors
- [ ] Paralysis
- [ ] TIA (mini stroke)
- [ ] Stroke

PSYCHIATRIC

- [ ] Memory loss or confusion
- [ ] Nervousness/anxiety
- [ ] Depression
- [ ] Suicide attempt

ENDOCRINE

- [ ] Heat intolerance
- [ ] Cold intolerance
- [ ] Neck swelling
- [ ] Increased drinking water
- [ ] Increased food intake

HEMATOLOGIC/LYMPHATIC

- [ ] Bruise easily
- [ ] Bleed easily
- [ ] Anemia
- [ ] Phlebitis
- [ ] Enlarged glands
- [ ] History blood transfusion

DATE ______________________________

PATIENT NAME: ______________________ **DATE OF BIRTH** ______________

PHARMACY NAME ______________________ **PHARMACY PHONE #** ______________

LOCATION ______________________ **PHARMACY FAX #** ______________

***Please list all medications including* **over the counter medications, vitamins antacids, herbal preparations** *that you are currently taking.*

Aspirin ☐ **Ibuprofen/Advil/Aleve** ☐ **Arthritis medication** ☐

DATE STARTED	NAME OF MEDICATION, DOSE	# of times per day	PRESCRIBED BY
	EXAMPLE		
9/10/2009	NEXIUM 40 MG	1 x per day	Dr. XYZ