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

MONROE OFFICE
Valley General Hospital
14701 – 179th SE, Monroe
(Main hospital entrance 2nd floor)

ANACORTES
Island Internal Medicine
912 – 32nd St # A
Anacortes

FRIDAY HARBOR
San Juan Health Center
689 Airport Circle #B
Friday Harbor

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

WHIDBEY ISLAND OFFICE
Whidbey Community Physicians
275 SE Cabot Dr. #101
Oak Harbor WA

WOODLANDS OFFICE
Woodlands Technology Bldg
1909 -214th St. SE # 211
Bothell (Canyon Park)

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 ***REGISTRATION FORM***

ACCOUNT#_____ **NEW** _____ **UPDATE** _____

PATIENT LAST NAME	**FIRST NAME (legal)**	**MI**	**PREFERRED OR NICKNAME**	**DATE OF BIRTH**

RACE	**ETHNICITY**	**PREFERRED LANGUAGE**	**SOCIAL SECURITY #**

SEX M ___ F ___ Other: _____ (Please List)	**GENDER IDENTITY:** __Genderqueer identifies as neither Male or Female __Identifies as Male __Female-to-male __Additional gender category or other, please specify _____ __Identifies as Female __Male-to-female __Choose not to disclose	**SEXUAL ORIENTATION** __ Choose not to disclose __ Heterosexual (straight) __ Bisexual __ Homosexual (gay/lesbian) __ Other _____

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**	**PREFERRED EMAIL ADDRESS**
( )	( )	( )	

REFERRING DOCTOR	**HOW DID YOU HEAR OF US?**	**MARITAL STATUS**
	Internet ___ Google Maps ___	MARRIED _____ DIVORCED _____ OTHER _____
PRIMARY CARE DOCTOR	Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___	SINGLE _____ WIDOWED _____ SEPARATED _____

PHARMACY NAME, PHONE NUMBER AND LOCATION

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**	**SUBSCRIBERS ID #**	**GROUP NUMBER**
	MALE ___ FEMALE ___ OTHER ____		

SECONDARY INSURANCE

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

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

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.) _____ **SPOUSE** _____ **PARENT** _____ **GUARDIAN**	**SOCIAL SECURITY #**	**LAST NAME**	**FIRST NAME**	**MI**
	STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**
	HOME PHONE ( )	**WORK OR CELL PHONE** **EXT** ( )	**DATE OF BIRTH**	**SEX** M __ F __ Other __

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**

Western
Washington
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FINANCIAL AGREEMENT

We consider all patients as "private" unless their insurance is one whom with 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 only 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 your 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.

A No-Show Fee for procedures of $250.00 will be charged if not cancelled a minimum of 72 hours prior to the procedure.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, 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_____

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

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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
- ☐ Headache
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Increased Appetite
- ☐ Decreased Appetite

SKIN
- ☐ Rash
- ☐ Skin Changes
- ☐ Dry Skin
- ☐ Pigmentation
- ☐ Moles

EYES
- ☐ Change in Visual Activity
- ☐ Blurred Vision
- ☐ Diplopia (Double Vision)
- ☐ Halos Around Lights
- ☐ Irritation/Pruritis
- ☐ Drainage
- ☐ Discharge

ENT
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Ear Ache
- ☐ Attacks of Vertigo
- ☐ Frequent Sinus Infection
- ☐ Rhinorrhea
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Voice/Vocalization Changes
- ☐ Difficulty Chewing or Swallowing

CARDIOVASCULAR
- ☐ Chest Pain/Pressure
- ☐ Palpitations
- ☐ Dyspnea (Shortness of Breath)
- ☐ Sycope
- ☐ Edema
- ☐ Leg Cramps/Calf Pain

RESPIRATORY
- ☐ Cough
- ☐ Hemoptysis (Coughing up Blood)
- ☐ Pleuritic Chest Pain
- ☐ Wheezing
- ☐ Dyspnea (Shortness of Breath)

GASTROINTESTINAL
- ☐ Frequent Heartburn
- ☐ Abdominal Pain
- ☐ Jaundice
- ☐ Blood in Stool
- ☐ Black Tarry Stools
- ☐ Painful Bowel Movements
- ☐ Constipation
- ☐ Diarrhea

GENITOURINARY (Female)
- ☐ Burning with Urination
- ☐ Hematuria
- ☐ Incontinence
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Menstrual Problems
- ☐ Painful Intercourse

GENITOURINARY (Male)
- ☐ Pain/Burning with Urination
- ☐ Hematuria
- ☐ Weak Stream
- ☐ Nocturia
- ☐ Testicular Pain or Swelling
- ☐ Erectile Dysfunction

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Back Pain
- ☐ Neck Pain

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness
- ☐ Syncope
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Difficulty Walking
- ☐ Memory Disturbance
- ☐ Speech Changes
- ☐ Tremor

HEMATOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ Easy Bruising/Bleeding
- ☐ Lymph node Enlargement

ENDOCRINE
- ☐ Polyuria
- ☐ Cold/Heat Intolerance
- ☐ Weight Changes
- ☐ Difficulty or Delayed Healing

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Unusual Stress

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2014 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