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 Medical Group

CONSENT TO RELEASE INFORMATION

(FAMILY AND FRIENDS)

I, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, PERMISSION TO DISCUSS MY MEDICAL CONDITION **(PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY). You may disclose health care information regarding testing, diagnosis, and treatment for the following:**

Please check all that apply: ____HIV (Aids virus) ____ Sexually transmitted diseases

_____Psychiatric disorders/mental health _____Drug and/or alcohol use

All health care information _____

Health care in my medical record related to the following treatment or condition: _____

_____

Health care information in my medical records for the date(s): _____

Other (e.g., x-rays, bills) specify date(s):_____

WITH: _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED

PATIENT SIGNATURE _____DATE _____

Western Washington Medical Group

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____ , acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgment
_____ Other (Please Specify)

_____

_____

_____ _____

Employee Name Date

This form will be retained in your medical record

Western Washington Medical Group

PLACE LABEL HERE

Spine / Initial Eval*

Present History

How did the pain start?

☐ Suddenly ☐ Fall ☐ Injured at work ☐ Injured during sports
☐ Gradually ☐ Bending ☐ Injured in auto accident ☐ No apparent cause
☐ Lifting ☐ Pulling ☐ Hit from behind ☐ Injured at home
☐ Other (specify below)

If other, please specify _____

Do you have any emotional reactions to your current problem? ○ Yes ○ No

If yes, what are the emotional reactions you have related to your current problem?

☐ I feel nothing matters ☐ I feel angry ☐ I feel sad (depressed)
☐ I feel frustrated ☐ I feel like taking my own life (suicidal) ☐ Nothing can help me

Pain

My pain is

☐ Present Intermittently ☐ Present but varies in intensity ☐ Improving
☐ Worse -present more often ☐ Worse - more intense ☐ Worse - changing in character ☐ Worse - changing in location

Please mark the severity of pain that corresponds to the area of your body. Rate how much pain hurts on an average day.

Back pain	○ 0 none	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 worst
Leg pain	○ 0 none	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 worst
Neck pain	○ 0 none	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 worst
Arm pain	○ 0 none	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 worst

Past Treatments for this Problem

Have you had any troubles with this problem before? ○ Yes ○ No

If yes, when was the FIRST time it happened: ___/___/___

Have you seen any other doctors for your current problem? ○ Yes ○ No

If yes, list their name and date seen _____

Which of the following treatments have you had for this problem?

○ Physical therapy ○ TENS Unit ○ Chiropractic Manipulation
○ Home exercise program ○ Epidural Steroid Injection ○ N/A - no prior treatments
○ Brace

If you answered yes to any of the post treatments listed above, please provide additional details below. If you have not had any prior treatments for this problem please continue to the next section.

Physical Therapy ___/___/___ Where? _____ # of Sessions: _____

if physical therapy, what was done and was it helpful? _____

Exercise ___/___/___ Are you currently doing home exercises? ○ Yes ○ No

Brace ___/___/___ If yes, what type of brace?

TENS Unit ___/___/___ Are you currently using a TENS unit? ○ Yes ○ No

Epidural Steroid Injection ___/___/___ Was it helpful and how long did it last? _____

Epidural Steroid Injection #2 ___/___/___ Was it helpful and how long did it last? _____

Epidural Steroid Injection #3 ___/___/___ Was it helpful and how long did it last? _____

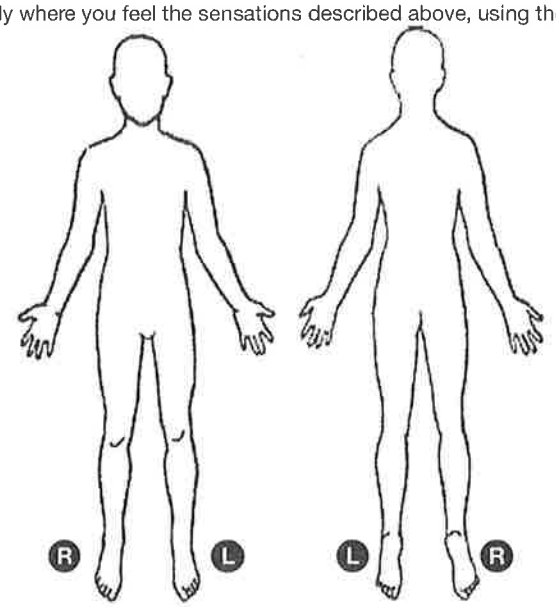
Chiropractic Manipulation ___/___/___ Was it helpful and for how long? _____

Western
Washington
Medical Group

Spine / Initial Eval*

Please continue to the next page...

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas to which your pain spreads.



✔ Stabbing
● Tingling
– Numbness
+ Pins and Needles
▲ Aching
× Burning

Do you have loss of bowel or bladder control? ○ Yes ○ No

My weight Is ○ Increasing ○ Decreasing ○ Steady

Are there any problems with weak muscles? ☐ None ☐ Weak in arms ☐ Weak in legs ☐ Generally weak

Sleep pattern ☐ No difficulty with sleep ☐ Unable to fall asleep ☐ Can't maintain sleep ☐ Wake frequently due to pain

Functional Activities

I can comfortably sit for ○ 1 min ○ 5 min ○ 10 min ○ 15 min ○ 20 min ○ 30 min ○ 45 min ○ 1 hour ○ 2 hours +

I can comfortably stand for ○ 1 min ○ 5 min ○ 10 min ○ 15 min ○ 20 min ○ 30 min ○ 45 min ○ 1 hour ○ 2 hours +

I can comfortably walk for ○ 1 min ○ 5 min ○ 10 min ○ 15 min ○ 20 min ○ 30 min ○ 45 min ○ 1 hour ○ 2 hours +

Daily Activities

I can do____ of my housework ○ All ○ Some ○ None

I can do_____ of my leisure activities ○ All ○ Some ○ None

I can do_____ of my work ○ All ○ Some ○ None

My sex life is
○ normal with no pain
○ normal with some pain
○ nearly normal, but painful
○ severely restricted by pain
○ nearly absent because of pain
○ absent, pain prevents any sex

Do you have any difficulty with sexual function? ○ Yes ○ No ○ N/A

Prior Tests

What tests have you had done for your problem? ☐ X-ray ☐ Myelogram ☐ CT ☐ Bone scan ☐ MRI ☐ EMG ☐ Discogram ☐ N/A

If you have had any of the tests listed above, please provide additional details if you know them.

X-ray ____/____/____ Where?_____ Results_____

Myelogram ____/____/____ Where?_____ Results_____

CT ____/____/____ Where?_____ Results_____

Bone Scan ____/____/____ Where?_____ Results_____

MRI ____/____/____ Where?_____ Results_____

EMG ____/____/____ Where?_____ Results_____

Where? Results

Western Washington Medical Group

Medical History*

Current Medications, inhalers, eye drops, patches...	**Dose and Frequency**	**What do you take it for?**

Supplements, Herbal remedies, currently taking	**Dose and Frequency**	**What do you take it for?**

Allergies	**Reaction that you had**	**Serious injuries or fractures**	
☐ Latex			
☐ Iodine			
☐ Penicillin		**Serious injuries or fractures**	
☐ Sulfa			
Other			
Other			
Other			
☐ Food Allergies:			

Review of Systems (check all that apply)

Constitutional	☐ Fever ☐ Chills	☐ Sweats ☐ Fatigue	☐ Recent weight loss	☐ No complaints
If recent weight loss, how many pounds lost?				
Skin	☐ Rashes	☐ Sores	☐ Scars	☐ No complaints
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Swelling hands/feet/ankles	☐ No complaints
Respiratory	☐ Short of breath	☐ Cough	☐ Coughing blood	☐ No complaints
Hematologic	☐ Bruise easily	☐ Bleeding disorder	☐ Blood clots	☐ No complaints
Stomach/Intestinal	☐ Heartburn	☐ Constipation	☐ Abdominal pain	☐ No complaints
Urology	☐ Pain with urination	☐ Incontinence	☐ Frequent urination	☐ No complaints
Musculoskeletal	☐ Stiffness	☐ Sprains	☐ Swelling	☐ No complaints
Neurological	☐ Headaches	☐ Numbness	☐ Dizziness	☐ No complaints
Mental Health	☐ Anxiety	☐ Depression	☐ Sleep problems	☐ No complaints

This form was completed by ○ Patient ○ Parent/Guardian

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record at Western Washington Medical Group.

X _____ DATE _____

Patient Name_____ Today's Date_____

REVIEW OF SYSTEMS

Have you had any of the following during the past year?
Please circle Yes if any apply to you

Cardiac
Chest pain ..... Yes
Swelling in legs/ Edema ..... Yes
Leg cramps or calf pain ..... Yes
Palpitations or arrhythmias ..... Yes

Constitutional/ General
Fevers ..... Yes
Headaches ..... Yes
Sleeping difficulty ..... Yes
Fainting ..... Yes

Eyes
Double or blurry vision ..... Yes
Wear Glasses or contacts ..... Yes
Eye disease or injury ..... Yes

Gastrointestinal
Blood in stool ..... Yes
Diarrhea ..... Yes
Constipation ..... Yes
Nausea or vomiting ..... Yes
Acid indigestion/ heartburn ..... Yes

Genitourinary
Blood in urine ..... Yes
Frequency in urination ..... Yes
Burning or painful urination ..... Yes
Incontinence or dribbling ..... Yes

Hematology
Bruises or bleeds easily..... Yes
Bleeding disorder..... Yes
Blood clot, DVT, or a Pulmonary embolism... Yes

Pulmonary
Shortness of breath ..... Yes
Wheezing ..... Yes
Asthma..... Yes
Frequent cough ..... Yes
COPD or Emphysema..... Yes

Skin
Rashes or itching..... Yes
Changes in moles or skin lesions Yes
Psoriasis..... Yes

Musculoskeletal
Limping..... Yes
Joint pain..... Yes
Joint stiffness..... Yes
Joint swelling..... Yes
Numbness to arm or leg..... Yes

Patient's Signature: _____
(or parent/legal guardian)

Practitioner's Initials_____

PAST MEDICAL HISTORY

Have you ever had any of the following?
Please circle Yes if any apply to you

Yes Diabetes
Yes Thyroid disorder
Yes Kidney or Renal disorder
Yes Stroke/TIA
Yes Seizures or Epilepsy

Yes Anemia
Yes Varicose Veins
Yes High Blood Pressure
Yes High Cholesterol
Yes Heart Problems _____

Yes Heart Attack/ Myocardial Infarction
Yes Heart Stents or Balloon Angioplasty
Yes Atrial Fibrillation
Yes Irregular Heartbeat

Yes Pacemaker
Yes Heartburn, Acid reflux
Yes Ulcers or Gastritis
Yes Esophagitis, Barrett's or Hiatal Hernia
Yes Seasonal Allergies
Yes Sleep Apnea, if Yes CPAP use? _____

Yes Tuberculosis
Yes Gout
Yes Cancer _____
Yes Migraines
Yes Depression

Yes Anxiety
Yes Fibromyalgia
Yes Chronic Pain _____
Yes Hepatitis A , B , C (circle which)
Yes HIV or exposure to it

Yes History of MRSA, VRE, Staph infections

Yes Anesthesia problems? _____
Yes Post Operative Nausea/Vomiting

Other Diagnoses or Symptoms that we should be aware of?

_____

_____

_____

Western Washington Medical Group

Medical History*

Surgery

Have you had surgeries for this problem? ○ Yes ○ No

If yes, please list surgeon, if it was helpful and what was done.

Have you had breast implants? (necessary for surgeries that require you to lie on your stomach) ○ Yes ○ No ○ N/A

Would you accept blood products or blood transfusion if necessary? ○ Yes ○ No

Have you ever had complications with surgery? ○ Yes ○ No

If so, please list the name of the surgery and any complications below. You may wish to include problems before, during, or after your procedure, as well as any problems you may have had with anesthesia.

Complication_____ Year_____

Complication_____ Year_____

Employment Status

Are you currently employed? ○ Yes ○ No Present employer _____

What is your occupation?_____ How long have you worked there?_____

My present job consists of: ☐ Ladders ☐ Lifting ☐ Sitting ☐ Standing ☐ Stairs ☐ Walking

Other Job Duties

Per work day, how many hours do you sit? ○ <1 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ >8

Per work day, how many hours do you stand? ○ <1 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ >8

How many pounds do you lift for your job? ○ <15 lbs ○ 15-25 lbs ○ 25-40 lbs ○ 40-60 lbs ○ >60 lbs

If unemployed or currently not working, please provide a date for at least one of the following.

Retired on ____/___/____ Total disability ____/___/____

Medical leave began ____/___/____ Social Security disability ____/___/____

Laid off ____/___/____ When did you last work? ____/___/____

Would your employer allow you to return to work with restrictions? ○ Yes ○ No

Social History

What sports, exercise activity, or hobbies do you participate in?_____

Do you live alone or as only adult in the house? ○ Yes ○ No

Alcohol use: Never Rarely Moderate Daily # of drinks ____ Recovery Treatment

Tobacco use: Never Yes, current packs/day____ How many years ____ Quit-year ____

This form was completed by ○ Patient ○ Parent ○ Guardian ○ POA ○ Family member ○ Other

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record.

X_____ DATE_____

OSSH
Orthopedic, Sports, Spine and Hand Center
Western Washington Medical Group

CANCELLATION FEE

A scheduled appointment is a commitment of time between the doctor and patient. We have reserved time just for you. When appointments are missed or canceled late, that time is lost.

We ask that when you schedule an appointment you make every effort to keep that appointment. We understand that emergencies do arise, and we will take that into consideration.

I acknowledge a $75.00 No Show Fee will be charged to me personally if I do not arrive for, or cancel my scheduled appointment without 24 hours notice.

DOCUMENT FEES

A Fee of $10 will be charged for any documents requiring your provider's review and signature. Payment of service will be required before documents are completed and/or forwarded. Commercial or private insurance are not financially responsible for this fee.

Patient Signature _____ Date of Birth _____

Print Name _____ Today's Date _____