WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF FAMILY MEDICINE

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 ____ GUARDIAN	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

	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 _____

Whitehorse Family Medicine

Western Washington Medical Group
875 Wesley St, Ste 250, Arlington, WA 98223
Phone 360-435-2233 Fax 360-435-3966

Name:_____ **Birth Date:**_____

Primary Objective of Your Appointment Today?

_____
_____

Chronic Medical Problems:

_____
_____
_____
_____
_____
_____

Medications:

Name	Strength	X/day

Allergies:

Medication	Reaction

Immunizations:
Last Tetanus:_____
Pneumonia: _____ Flu: _____

Past Surgeries:

Name Surgery	Month/Year

Past Diagnostic Procedures
(colonoscopy/US/MRI/Ct Scan/etc):

Name Procedure/Findings	Month/Year

Family History:
(if deceased, manner/age of death)
Dad: _____
Mom: _____
Siblings: _____
_____
_____
Other: _____

Social History:
Employment: _____
Marital Status: _____
Religious preference: _____
Alcohol: Y / N
Type_____
Quantity per week _____
Tobacco: Y / N
Type: _____
If history, year quit: _____
Caffeine Use: Y / N
Illicit Drugs: _____
Hobbies:_____
_____
_____

Would you like to discuss Advanced Directives?
Yes / No

Review of Systems

67 Family Medicine

Please check any symptoms you are having.

General

_____ Chills
_____ Daytime Sleepiness
_____ Fatigue
_____ Fever
_____ Loss of Appetite
_____ Very Low Energy
_____ Night Sweats
_____ Severe Snoring
_____ Trouble Sleeping
_____ Unexpected Weight Loss

ENT

_____ Decreased Hearing
_____ Difficulty Swallowing
_____ Ear Discharge
_____ Earache
_____ Face or Jaw Pain
_____ Hoarseness
_____ Nasal Congestion
_____ Nosebleeds
_____ Post Nasal Drip
_____ Ringing in the Ears
_____ Sore Throat

Breasts

_____ Abnormal Mammogram
_____ Bloody Discharge from Nipple
_____ Breast Enlargement
_____ Breast Pain
_____ Breast Lump
_____ Nipple Discharge

GI

_____ Abdominal Bloating
_____ Bloody Stools
_____ Abdominal Pain
_____ Change in Bowel Habits
_____ Constipation
_____ Dark Tarry Stools
_____ Diarrhea
_____ Yellowish Skin Color

Eyes

_____ Blurred Vision
_____ Discharge
_____ Double Vision
_____ Eye Irritation
_____ Eye Pain
_____ Light Sensitivity
_____ Loss of Vision

CV

_____ Chest Pain or Discomfort
_____ Calf Pain with walking
_____ Difficulty Breathing at Night
_____ Difficulty Breathing laying down
_____ Fainting or Near Fainting
_____ Leg Cramps
_____ Lightheadedness
_____ Palpitations or Racing Heart
_____ Paroxysmal Nocturnal Dyspnea
_____ Peripheral Edema
_____ Recent Weight Gain
_____ Shortness of Breath with Exertion
_____ Swelling in Extremities

Resp

_____ Chest Pain with Deep Breaths
_____ Cough
_____ Coughing up Blood
_____ Excessive Mucus or Phlegm
_____ Excessive Snoring
_____ Excessive Sputum
_____ Pleuritic Chest Pain
_____ Shortness of Breath
_____ Wheezing

_____ Trouble Swallowing
_____ Heartburn
_____ Hemorrhoids
_____ Indigestion
_____ Nausea
_____ Pain with swallowing
_____ Vomiting
_____ Vomiting Blood

*update 1.2014

Review of Systems Continued

GU

Female

_____ Blood in Urine
_____ Decreased Sex Drive
_____ Discharge
_____ Genital Sores
_____ Night time urination
_____ Urinary Frequency
_____ Trouble Starting Urinary System
_____ Pain with urination
_____ Heavy or Prolonged Periods
_____ Irregular or Missed Periods
_____ Hot Flashes
_____ Pain with Intercourse
_____ Painful Periods
_____ Pelvic Pain
_____ Spotting

Male

_____ Blood in Urine
_____ Decreased Libido
_____ Discharge
_____ Pain with Urination
_____ Erectile Dysfunction
_____ Genital Sores
_____ Urination at Night
_____ Trouble Starting urinary system
_____ Urinary frequency
_____ Urinary Hesitancy
_____ Urinary Urgency
_____ Urine Weakness
_____ Urine Incontinence

Derm

_____ Change in Hair or Nails
_____ Dry Skin
_____ Excessive Perspiration
_____ Itching
_____ Non-Healing Sores
_____ Rash
_____ Skin Cancer
_____ Suspicious mole or growth
_____ Suspicious Lesions
_____ Unusual Hair Distribution

Psych

_____ Anxious Mood
_____ Depressed Mood
_____ Excessive Worrying
_____ Fears of Phobias
_____ Frightening Visions or Sounds
_____ Sleep Problems
_____ Thoughts of Suicide
_____ Thoughts of Violence to others

Endo

_____ Cold Intolerance
_____ Excessive Hunger
_____ Excessive Thirst
_____ Excessive Urination
_____ Heat Intolerance
_____ Weight Change

MS

_____ Back Pain
_____ General Weakness
_____ Joint Pain
_____ Joint Swelling
_____ Muscle Aches
_____ Muscle Cramps
_____ Muscle Weakness
_____ Stiffness

Neuro

_____ Arm or Leg Weakness
_____ Confusion
_____ Dizziness or sensation of spinning
_____ Facial Weakness
_____ Falling Down
_____ Headaches
_____ Loss of Consciousness
_____ Numbness or Tingling
_____ Poor Balance or Coordination
_____ Poor Memory
_____ Seizures or Uncontrolled Movements
_____ Slurred Speech
_____ Tremors
_____ Trouble with concentration
_____ Visual Disturbances

Heme

_____ Enlarged Glands
_____ Excessive or Easy Bruising

Allergy

_____ Possible HIV Exposure
_____ Persistent Infections
_____ Seasonal Allergies

Western Washington Medical Group
Whitehorse Family Medicine

FINANCIAL AGREEMENT

We consider all patients as "**private pay**" 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 pay**" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. Insurance normally covers only 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. It is the patient's responsibility to check their insurance plan coverage prior to being seen to see if the specified reason for your visit is a covered benefit. *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 may 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 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.

Patient's Printed Name _____ DOB _____

Signature _____ Date _____

Western Washington Medical Group
Whitehorse Family Medicine

Patient No-Show and Cancellation Policy

We strive to provide excellent medical care to our patients. In order to be consistent with this, we have a Patient No-Show and Cancellation Policy that we have adopted for our clinic. When an appointment is scheduled, that time has been reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient.

Our policy is as follows: You may cancel your appointment at or before 8:00 a.m. on the day of scheduled appointment with no consequences. We will be happy to reschedule the appointment for you and leave the open time for another patient. If you miss your appointment or cancel any time after 8:00 a.m. the day of your appointment, Western Washington Medical Group, Department of Family Medicine reserves the right to bill you **$50.00** for each no-show or late cancellation. This fee is the patient's responsibility and is not billable to insurance.

Additionally, if a patient is more than 15 minutes late to his/her appointment without prior notification, we reserve the right to cancel the appointment and the cancellation fee of **$50.00** will apply.

We do realize that on rare occasions emergencies or circumstances may arise beyond your control. We will address these situations with you should that occur.

If you have any questions regarding this policy, please direct them to the practice administrator. We thank you for working with us to ensure that we are able to provide the best service possible to all of our patients.

I have read and understand the Patient No-Show and Cancellation Policy of the practice and I agree to the terms. I also understand that such terms may be amended periodically by the practice.

Printed Patient name: _____ Date: _____

_____
Signature

Western Washington Medical Group
Whitehorse Family Medicine

ACKNOWLEDGEMENT 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 acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

_____

_____

_____ _____

Employee Name Date

This form will be retained in your medical record

Western Washington Medical Group
Whitehorse Family Medicine

CONSENT TO RELEASE INFORMATION

(FAMILY AND FRIENDS)

I give the physicians and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition.

WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic.)

[ ] HIV (Aids virus)

[ ] Sexually Transmitted Diseases (STD's)

[ ] Psychiatric disorders/Mental health

[ ] Alcohol/Substance abuse

[ ] All other Health Information

Other: _____

WWMG/WFM may disclose this information to the following individuals:
(Please list family members and friends only)

NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

RELATIONSHIP: _____ PHONE: _____

This is an indefinite consent form unless otherwise specified

Printed Patient's name: _____

_____ _____

Signature Date

Whitehorse Family Medicine
Western Washington Medical Group
875 Wesley St, Ste 250, Arlington, WA 98223
phone 360-435-2233 fax 360-435-3966

Authorization For Disclosure Of Health Information

1) I hereby authorize: _____

Address: _____

To disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____
_____ Telephone: _____

Covering the Period(s) of Health Care

From (date): _____ To (date): _____
From (date): _____ To (date): _____

2) This information is to be sent to (name): _____

Address: _____

For the purpose of: _____

3) General information to be disclosed:

- o Complete Health Records
- o Consultation Reports
- o X-ray Reports
- o X-ray Films
- o Immunization Records
- o History & Physical Exam
- o Progress Notes
- o Laboratory Tests
- o Surgical Results
- o Other (Please Specify)

I understand that this will include information relating to (check and initial ONLY if information is to be sent):

- o Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV) Infection _____
- o Sexually Transmitted Diseases (STD) _____
- o Behavioral Health Service/Mental Health/Psychiatric Care _____
- o Treatment for Alcohol and/or Drug Abuse _____

4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

5) Whitehorse Family Medicine, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

6) Please allow up to three weeks to receive your record. There may be a cost to copy your record. Please inquire at the front desk for further information.

7) Your records may be re-disclosed by the party that we are releasing them to, and therefore no longer protected by law.

SIGNED: _____ _____
Patient Date

_____ _____
Or Legal Representative (relationship to patient) Date