



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? Internet ___ Google Maps ___ Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___		MARITAL STATUS MARRIED ___ DIVORCED ___ OTHER ___ SINGLE ___ WIDOWED ___ SEPARATED ___				
PRIMARY CARE DOCTOR									
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 MALE ___ FEMALE ___ OTHER ___		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 ___ OTHER ___		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.) ___ 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 by voicemail, text, email or portal, which may contain details of my medical condition. By voluntarily providing your mobile phone number to WWMG, you agree to receive recurring non-marketing SMS messages regarding appointment reminders, cancellation or rescheduling, patient onboarding, care-related notifications, and billing updates. Message frequency varies. Message and data rates may apply. Providing a mobile number and consenting to SMS messages are not required to receive medical treatment or services from WWMG. Reply HELP for help or STOP to opt out. View the WWMG Privacy Policy and SMS Terms and Conditions.									
INITIALS				VOICEMAIL #					
PATIENT SIGNATURE Type name for signature				DATE					
For office use only									
Dr. _____		Ins. code		Acct #		Initials			

NEW PATIENT INFORMATION

Date of service: ____/____/____

Name: _____ Age: _____ Date of birth: ____/____/____ Gender: M / F

Preferred pharmacy: _____ Allergies to any medications, X-ray dye, or other: Yes / No

If yes, which substance and type of reaction: _____

CURRENT MEDICATIONS AND SUPPLEMENTS

Name:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY OF ILLNESS

Alzheimer's	Yes / No	Mother / Father	
Parkinson's	Yes / No	Mother / Father	
Cancer	Yes / No	Mother / Father	Type: _____
Heart disease	Yes / No	Mother / Father	
Diabetes	Yes / No	Mother / Father	Type: _____
Stroke	Yes / No	Mother / Father	
Hypertension	Yes / No	Mother / Father	
Alcoholism	Yes / No	Mother / Father	
Bleeding disorder	Yes / No	Mother / Father	
Mental illness	Yes / No	Mother / Father	Type: _____

SOCIAL HISTORY

Do you consume (circle all that apply): coffee / tea / energy drinks / alcohol / tobacco / vape / marijuana

If any, which one(s) and daily amount: _____

OPERATIONS AND HOSPITALIZATIONS

Reason:	Date:	Place:	Provider:
_____	_____	_____	_____



Registration Packet

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.

Accounts that are past due with no response to billed invoices must call our billing department to coordinate payments ASAP; otherwise the patient may be terminated from the practice, and may suffer financial penalties and/or be sent to collections.

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, may be responsible for payments of interest on the unpaid balance of 9% 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 provider to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my provider.

No-Show/Late Cancellation Fee: All WWMG clinics require a minimum 24-hour notice of any appointment cancellations or reschedules, including telehealth appointments. No show appointments will be charged \$50-75. After 3 no show appointments and/or late cancellations (with less than a full 24hr notice to our clinic), you will be asked to leave the practice.

Missed appointments take up valuable time.

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

Printed Name _____

DOB _____

Signature _____

Date _____



Western Washington
Medical Group

Registration Packet

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 Representatives 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: _____

Employee Name

Date

This form will be retained in your medical record



Registration Packet

Consent to Release Information to Friends and Family

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. *(NOTE: if a specific topic box is not checked, we will be unable to discuss any treatment related to that topic.)*

WWMG MAY DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS AND TREATMENT FOR THE FOLLOWING CONDITIONS:

- | | |
|--|---|
| ☐ HIV (Aids virus) | ☐ Sexually Transmitted Infections (STIs) |
| ☐ Psychiatric disorders / Mental health | ☐ Alcohol / Substance abuse |
| ☐ All other health information | |

Other: _____

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.

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

Second Phone Number

Check one: Cell Work Home

Ok to leave detailed message?: Y N

Check one: Cell Work Home

Ok to leave detailed message?: Y N

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