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

Comprehensive Patient Health History

Patient Name_____ Age_____ Today's Date_____

Current Weight_____ Height_____ ☐ Right Handed ☐ Left Handed

Describe your main medical problem_____ Date of injury_____

List all symptoms_____ Primary Care Dr. _____

_____ Referring Doctor_____

Please rate your pain on a scale of 1-10 (#10 being the worst) _____

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**
☐ Latex	
☐ Iodine	
☐ Penicillin	
☐ Sulfa	
Other_____	
Other_____	
Other_____	
☐ Food Allergies:	

Serious Injuries or fractures

_____ _____

_____ _____

All previous surgeries or major procedures (year?)

_____ _____

_____ _____

_____ _____

_____ _____

Patient Social History: Occupation: _____

Work status: ☐Regular duties ☐Light/modified duties ☐Retired ☐Disabled ☐Currently Unemployed

Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Alcohol use: ☐Never ☐Rarely ☐Moderate Daily#of drinks_____ ☐Recovery Treatment

Tobacco use: ☐Never ☐Yes,current packs/day_____ How many years _____ ☐Quit-year _____

Recreational drugs: ☐Never ☐Yes_____How often_____ ☐Recovery treatment program

Family Medical History	Age	Diseases	If deceased, cause of death
Father			
Mother			
Sibling			
Sibling			

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?

_____

_____

_____

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 _____