

**Western Washington Medical Group dba Snohomish Family Medicine**  
**DEPARTMENT OF FAMILY MEDICINE Unit #63**

**REGISTRATION FORM**

**ACCOUNT#** \_\_\_\_\_ **NEW** \_\_\_\_\_ **UPDATE** \_\_\_\_\_

Patient Last Name:		First Name:		MI:	Preferred or Nickname:		
Date of Birth:	Sex: M    F	Race:		Social Security #:			
Mailing Address:		Apt #	City:	State:	Zipcode 4 digit		
Street Address:		Apt #	City:	State:	Zipcode 4 digit		
Home Phone: (    )		Work Phone: (    )		Ext:	Cell Phone: (    )		
Referring Doctor:			Marital Status: Married ___ Divorced ___ Other ___ Single ___ Widowed ___ Separated ___				
Primary Care Doctor:			Preferred Email Address:				
Pharmacy Name, Phone Number, and Location:			Preferred Email Address:				
<b>PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED _____ OR DISABLED _____)</b>							
Employer Name:			Occupation:				
Street Address:		City:	State:	Zipcode 4 digit			
<b>PRIMARY INSURANCE:</b>							
Insurance Company Name:			Relation to Subscriber		Copay		
Subscriber's Name			Subscribers Employer				
Subscribers Date of Birth	Subscribers Sex M    F	Subscribers ID#			Group #		
<b>SECONDARY INSURANCE:</b>							
Insurance Company Name:			Relation to Subscriber		Copay		
Subscribers Name			Subscribers Employer				
Subscribers Date of Birth	Subscribers Sex M    F	Subscribers ID#			Group #		
Emergency Contact <i>(NOT LIVING WITH YOU)</i>		Name:	Relationship		Phone #	Home/Work/Cell	
<b>RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?</b>							
<input type="checkbox"/> Self <small>(if self, do not fill in right field)</small> <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	Social Security #		Last Name		First Name		MI
	Street Address:			City:	State:	Zip Code:	
	Home Phone:		Work or Cell Phone		Ext:	Date of Birth	Sex M    F
	Workers Comp Claim #		Date of Injury	Employer		State or Self Insured?	
How did you hear about us?							
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.							
Patient Signature: _____				Initials _____	Date _____		Voicemail # _____
For office use only: Dr. _____ Ins. Code _____ Acct# _____							

# History Data Base

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ What is your Religious preference? \_\_\_\_\_

Date:	Past Surgeries or Serious Illness:	Current Medications:	Drug Allergies:

**Check Below if you have ever had:**

<b>Cardiovascular</b> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Stroke <input type="checkbox"/> Blood Clots	<b>Gastrointestinal</b> <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Gall Stone <input type="checkbox"/> Liver Disease or Hepatitis <input type="checkbox"/> Esophageal Reflux <input type="checkbox"/> Bowel Problems <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids	<b>Genitourinary</b> <input type="checkbox"/> Urinary Infections <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Venereal Disease	<b>Mental/Neurologic</b> <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Seizure or Convulsion <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Alcohol Problem <input type="checkbox"/> Sleep Disorder
<b>Respiratory</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Allergies or Hay Fever	<b>Musculoskeletal</b> <input type="checkbox"/> Gout <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back Problems <input type="checkbox"/> Fibromyalgia	<b>Blood</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Tendency <b>Endocrine</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease	<b>Other</b> <input type="checkbox"/> Skin Problems <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer <input type="checkbox"/> Cancer Type: _____

Comments: \_\_\_\_\_

**Specify which relatives have had:**

High Blood Pressure Heart Disease Stroke Tuberculosis Bleeding Disorder Thyroid Disease	Father:    Mother:    Others: <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____	Diabetes Mental Illness/suicide Alcoholism Cancer Type of cancer _____ Other Illness: _____	Father:    Mother:    Others: <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____
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**List name and year of birth for each current member of your household:** Spouse & Children: \_\_\_\_\_  
 Others: \_\_\_\_\_

<b>Habits: Tobacco</b> <input type="checkbox"/> Cigarettes ___Packs per day <input type="checkbox"/> Chew ___No. of years <input type="checkbox"/> Cigar/Pipe ___Year quit	<b>Alcohol:</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> I have a problem with alcohol	<b>Coffee / Caffeine:</b> _____ Cups per day <b>Other Drug Use:</b> _____
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<b>Education</b> <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Other _____	<b>Employment:</b> Self _____ Spouse _____	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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<b>Height and Weight</b> Current Weight _____ Height _____ Usual Weight _____ <input type="checkbox"/> I have a weight problem	<b>Women:</b> _____ Pregnancies              _____ Miscarriages _____ Living Children              _____ Abortions Current birth control method: _____
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Primary Care Provider Name: \_\_\_\_\_ Review / Update: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Review of Systems: Please circle any symptoms you are currently experiencing.**

**General**

chills  
daytime sleepiness  
fatigue  
fever  
loss of appetite  
malaise  
night sweats  
severe snoring  
trouble sleeping  
unexpected weight loss

**Eyes**

blurred vision  
discharge  
double vision  
eye irritation  
eye pain  
light sensitivity  
loss of vision

**Ears, Nose, & Throat**

decreased hearing  
difficulty swallowing  
ear discharge  
earache  
face or jaw pain  
hoarseness  
nasal congestion  
nosebleeds  
nasal discharge  
ringing in the ears  
sore throat

**Cardiovascular**

chest pain or discomfort  
calf pain with walking  
difficulty breathing at night  
difficulty breathing laying down  
fainting or near fainting  
leg cramps  
lightheadedness  
discomfort breathing relieved by sitting or standing  
palpitations or racing heart  
hard time breathing when lying down  
peripheral edema  
recent weight gain  
shortness of breath with exertion  
swelling in extremities  
syncope

**Breast**

abnormal mammogram  
bloody discharge from nipple  
breast enlargement  
breast pain  
breast lump  
nipple discharge

**Respiratory**

chest pain with deep breaths  
cough  
coughing up blood  
excessive mucus or phlegm  
excessing snoring  
excessive sputum  
hemoptysis  
pleuritic chest pain  
shortness of breath  
wheezing

**Gastrointestinal**

abdominal bloating  
abdominal pain  
bloody stools  
change in bowel movements  
constipation  
black tarry stools  
diarrhea  
trouble swallowing  
heartburn  
hemorrhoids  
indigestion  
nausea  
pain with swallowing  
vomiting  
vomiting blood  
yellowish skin color

**Genitourinary - Women**

blood in urine  
decreased sex drive  
discharge  
pain with urination  
genital sores  
heavy or prolonged periods  
hot flashes  
irregular or missed periods  
nighttime urination  
pain with intercourse  
painful periods  
pelvic pain  
spotting  
trouble starting urinary system  
urinary frequency  
urinary hesitancy  
urinary urgency  
urinary incontinence

**Musculoskeletal**

neck pain  
thoracic pain  
lumbar pain  
general weakness  
joint pain  
joint swelling  
muscle aches  
muscle cramps  
muscle weakness  
stiffness

**Skin**

change in hair or nails  
dry skin  
excessive perspiration  
itching  
non-healing sores  
rash  
skin cancer  
suspicious lesions  
unusual hair distribution

**Neurologic**

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 concentrating  
visual disturbances

**Mental Health**

depressed mood  
anxious mood  
fears or phobias  
frightening visions or sounds  
thoughts of suicide  
thoughts of violence to others

**Endocrine**

intolerance to cold  
intolerance to heat  
excessive hunger  
excessive thirst  
excessive urination

**Blood**

enlarged glands  
excessive or easy bruising  
prolonged bleeding

**Allergy**

hives or rash  
persistent infections  
possible HIV exposure  
seasonal allergies

**Other:**

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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 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.**

\_\_\_\_\_  
*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*

## No Show/ 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 up until **24 hours before** your scheduled appointment with no consequences. We will be happy to reschedule the appointment for you and leave the open time for another patient to be seen. If you miss your appointment or cancel anytime 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 10 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 at that time.

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 services are provided to all our patients in the best possible way.

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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.

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Signature of Patient

Date

## Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, {PATIENT.LABELNAME}, 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*

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### 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

## Consent to Release Information to Friends and Family

I give the physicians 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:**

- |  |   |
|--|---|
| <input type="checkbox"/> HIV (Aids virus)                      | <input type="checkbox"/> Sexually Transmitted Infections (STIs) |
| <input type="checkbox"/> Psychiatric disorders / Mental health | <input type="checkbox"/> Alcohol / Substance abuse              |
| <input type="checkbox"/> 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 time.

<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
<i>Name</i>	<i>Relationship</i>	<i>Phone</i>

**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	Third phone number
(Circle one) Cell Work Home OK to leave detailed message?: Y N	(Circle one) Cell Work Home OK to leave detailed message?: Y N	(Circle 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*