

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.)		SOCIAL SECURITY #		LAST NAME		FIRST NAME		MI
___ SPOUSE		STREET ADDRESS			CITY	STATE	ZIP CODE 4 DIGIT	
___ PARENT		HOME PHONE ()		WORK OR CELL PHONE ()		EXT	DATE OF BIRTH	
___ GUARDIAN							SEX M ___ F ___ Other ___	
WORKERS COMP CLAIM #		DATE OF INJURY		EMPLOYER			STATE OR SELF INSURED?	
<p>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.</p>								
PATIENT SIGNATURE _____				INITIALS _____				
				VOICEMAIL # _____				
				DATE _____				
For office use only								
Dr. _____		Ins. code _____		Acct # _____		Initials _____		

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:

Cardiovascular <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	Gastrointestinal <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	Genitourinary <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	Mental/Neurologic <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
Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Allergies or Hay Fever	Musculoskeletal <input type="checkbox"/> Gout <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back Problems <input type="checkbox"/> Fibromyalgia	Blood <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Tendency Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease	Other <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: _____

Habits: Tobacco <input type="checkbox"/> Cigarettes ___Packs per day <input type="checkbox"/> Chew ___No. of years <input type="checkbox"/> Cigar/Pipe ___Year quit	Alcohol: <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	Coffee / Caffeine: _____ Cups per day Other Drug Use: _____
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Education <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Other _____	Employment: Self _____ Spouse _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Height and Weight Current Weight _____ Height _____ Usual Weight _____ <input type="checkbox"/> I have a weight problem	Women: _____ 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 - Men

blood in urine
decreased libido
discharge
pain with urination
erectile dysfunction
genital sores
nighttime urination
trouble starting urination
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:

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.

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.

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

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

<i>Signature of client (or personal representative)</i>	<i>Date</i>
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If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

<i>Personal Representative's Name</i>	<i>Relationship to Client</i>
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