



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			

Patient's Name: _____ Birthdate: _____

Parent's Name: _____

List any medication allergies: _____

List any long-term illnesses or surgeries: _____

List any significant allergies or infectious diseases: _____

Family History:

	DOB	Health Condition
Father		
Mother		
Sibling		
Sibling		
Sibling		
Sibling		

Which relative has had the following:

- _____ Diabetes
- _____ Heart Attacks/Strokes
- _____ Allergies or Asthma
- _____ Epilepsy or Neurologic Condition
- _____ Depression or Mental Illness
- _____ Alcohol Problems
- _____ Smokers in the Home
- _____ High Cholesterol
- _____ ADHD
- _____ Other _____

Birth and Development History:

Any problems during pregnancy or delivery? _____

Birthweight _____ Age at which patient rolled over _____, Sat by self _____, Walked _____, spoke first words _____. Any learning disabilities _____, behavior problems _____.

Check Below If Patient Has Ever Had:

- | | | | |
|---|---|--|--|
| ☐ Diabetes | ☐ Asthma | ☐ UTI | ☐ School Problems |
| ☐ Hearing Loss | ☐ Heart Murmur | ☐ Joint Pain | ☐ Depression |
| ☐ Eye Problems | ☐ Abdominal Pain | ☐ Back Trouble | ☐ Suicide Attempt |
| ☐ Nasal Allergies | ☐ Constipation | ☐ Skin Problems | ☐ Smoking Habit |
| ☐ Multi Ear Infections | ☐ Diarrhea | ☐ Acne | |
| ☐ Breathing Problems | ☐ Bedwetting | ☐ Eczema | |

Immunization Dates – If you are not sure, please give approximation with question mark behind it.

Polio	MMR	Td Adult	Varicella	List Other	Date
____/____/____	____/____/____	____/____/____	____/____/____	_____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____	_____	____/____/____
____/____/____	HIB	____/____/____	____/____/____	_____	____/____/____
____/____/____	____/____/____	PCV	____/____/____	_____	____/____/____
DTaP	____/____/____	____/____/____	____/____/____	_____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____	_____	____/____/____
____/____/____	Hep B	____/____/____	____/____/____	_____	____/____/____
____/____/____	____/____/____	Flu	____/____/____	_____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____	_____	____/____/____

Date Reviewed: ____/____/____

Reviewed By: _____

____/____/____
____/____/____

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
excessive 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:**

☐ 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 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