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

ACCOUNT# _____ NEW_____ UPDATE _____

Patient Last Name:	First Name:		MI:	Preferred or Nickname:	
Date of Birth:	Sex: M F	Race: Ethnicity:	Social Security #: Preferred Language:		
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:					
Pharmacy Name, Phone Number, and Location:		Preferred Email Address:			

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED _____ OR DISABLED _____)

Employer Name:	Occupation:		
Street Address:	City:	State:	Zipcode 4 digit

PRIMARY INSURANCE:

Insurance Company Name:	Relation to Subscriber	Copay	
Subscriber's Name	Subscribers Employer		
Subscribers Date of Birth	Subscribers Sex M F	Subscribers ID#	Group #

SECONDARY INSURANCE:

Insurance Company Name:	Relation to Subscriber	Copay	
Subscribers Name	Subscribers Employer		
Subscribers Date of Birth	Subscribers Sex M F	Subscribers ID#	Group #

Emergency Contact *(NOT LIVING WITH YOU)*	Name:	Relationship	Phone # 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:
	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.

_____
Initials Voicemail #

Patient Signature: _____ **Date** _____

For office use only:
Dr. _____ Ins. Code _____ Acct# _____

WWMG Snohomish Family Medicine

Pediatric History Data Base

(0-12 yrs.)

Today's Date: _____

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:

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

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

Polio	__ / __ / __	MMR	__ / __ / __	Td Adult	__ / __ / __	**List Other**	**Date**
	__ / __ / __		__ / __ / __	Varicella	__ / __ / __	_____	__ / __ / __
	__ / __ / __	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
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 <u>any</u> 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.

Name	*Relationship*	*Phone*
Name	*Relationship*	*Phone*
Name	*Relationship*	*Phone*

<u>Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.</u>
Please provide us with **YOUR best, most** current phone contact information. This information will become part of your permanent medical record *<u>unless/until you change it.</u>* 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*