Western Washington Medical Group
Gastroenterology

APPOINTMENT SCHEDULED: _____ CHECK IN TIME: _____

WITH DOCTOR: _____ PHONE: (425) 259-3122 (For all offices)

EVERETT OFFICE
43RD & Hoyt Medical Bldg
4225 Hoyt Ave, Suite A
Everett, WA 98203

ENDOSCOPY CENTER
Providence Regional Mill Creek
12800 Bothell-Everett Hwy, Ste 200
(Also known as 19th Ave SE or Hwy 527) Everett, WA 98208

In an effort to make you more at ease on your first visit to our office, we have enclosed a packet of information and forms to read, fill out at your leisure at home, and **bring to your appointment**. Here is a checklist of the forms that are enclosed and short explanation of each:

- **Blood Thinners and Cardiac Devices:** This is required for any scheduled procedure. If this does not apply to you, leave it blank.
- **Registration Form:** Please remember to bring **all of your insurance cards**. We will need to scan a copy of the front and back of the card(s). If **your insurance plan requires a copayment**, this will be collected at time of your appointment. If your **insurance plan requires a referral** it is your responsibility to obtain one from your primary care provider, prior to this office visit. If you have difficulty obtaining the referral from your primary care provider, please call our referral coordinator at (425) 259-3122 for assistance.
- **Friends and Family Release:** List the family members, friends, or caregivers that you wish to have access to your private healthcare information. We are required by law to have your signature on this disclosure form.
- **Medical History Form:** It is important to complete the form in full. This will enable us to care for you appropriately. If you require additional space, please write on a separate sheet of white paper and attach it to the history form.
- **Medications Form:** Please list all of your current prescribed medications that you are taking. Include the dosage and how often you take them. You should also list any herbal or over the counter medications, vitamins, minerals, etc. that you take on a regular basis.
- **Directions and map:** Please be sure that you note the correct office location for your appointment.

It is our hope that you will find this material informative and that by completing these forms in advance of your appointment your time in our office will be efficient. Thank you for your time and attention, we look forward to participating in your medical care.

Western Washington Medical Group
Gastroenterology

Blood Thinners and Cardiac Devices

The following information is required to schedule any procedure(s) that your GI provider may order.

For your safety, we need to get a clearance to hold your prescription blood thinner **PRIOR** to scheduling your appointment.

If you are taking any of the **following** medications please check the box below.

Name of Medications:

- ☐ Warfarin (Coumadin, Jantoven)
- ☐ Plavix (Clopidogrel)
- ☐ Pradaxa (Dabigatran)
- ☐ Eliquis (Apixaban)
- ☐ Effient (Prasugrel)
- ☐ Savaysa (Edoxaban)
- ☐ Brilinta (Ticagrelor)
- ☐ Cilostazol (Pletal)
- ☐ Other _____

Name of physician/PA-C/ARNP on your prescription bottle and their location/Medical Group:

_____

Device Clearance

For your safety, we need to get a clearance for your Cardiac Defibrillator/Pacemaker **PRIOR** to scheduling your appointment.

We need to know

Name/Type of Cardiac Device: _____

Name of Provider/Facility who manages your device and their location/Medical Group:

_____

Please note that if we do not receive this information, your procedure(s) may not be scheduled, or may be canceled, until correct information is received.

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

PRIMARY CARE 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 ☐

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 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 ***DATE***
Type name for signature

For office use only

Dr._____ **Ins. code**_____ **Acct #**_____ **Initials**

Western Washington Medical Group
Gastroenterology

FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information.

I will rely on the professional judgement of my provider and their designee to share such information, as they deem necessary and appropriate. I understand that information is limited to verbal discussions and that no paper copies of my **Personal Healthcare Information (PHI) will be provided without my signature** to release information from my medical record. I, the patient, may be asked to sign a Release of Information (ROI) to allow WWMG to share information if my provider and their designee deem it necessary.

This consent will be considered valid until such time that I, the patient, revoke it. I reserve the right to revoke this 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: _____

Patient's Personal Phone Information

Note: This is different from the above information.

Please provide YOUR most current phone contact information. This information will become part of your permanent medical record until you change it. You can change this information by completing a new form at any time.

Please note: By choosing the option to leave a detailed message, you are allowing us to leave sensitive health information and specific details related to referrals.

First phone number: _____ Cell Home Work OK to leave detailed message: YES NO

Second phone number: _____ Cell Home Work OK to leave detailed message: YES NO

Third phone number: _____ Cell Home Work OK to leave detailed message: YES NO

_____
PATIENT OR GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT

_____
PRINTED NAME

_____
DATE

Western Washington Medical Group
Gastroenterology

MEDICAL QUESTIONNAIRE

Name: _____ Date of birth: _____ Age: _____

Referring physician: _____ Primary Care physician: _____

Reason for visit: _____

What makes the problem better or worse? What medications have you tried?

_____

GI Review of Systems: *CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED, IF IN DOUBT PUT A QUESTION MARK*

- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Food sticking
- ☐ Regurgitation
- ☐ Heartburn
- ☐ Ulcers
- ☐ Helicobacter pylori
- ☐ Nausea/vomiting
- ☐ Bloating/gas
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Liver problems
- ☐ Viral hepatitis
- ☐ IV drug use
- ☐ Weight loss (last 6 months)
- ☐ Colon polyps
- ☐ Hemorrhoids
- ☐ Food intolerance
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Barrett's esophagus
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ Bloody stool
- ☐ Black stool
- ☐ Hard stools
- ☐ Soft stools
- ☐ Anal problem

☐ Other symptoms/complaints: _____

Have you had a colonoscopy? Yes ☐ No ☐ Year _____ Next surveillance due _____

Have you had an upper endoscopy (EGD)? Yes ☐ No ☐ Year _____

Illnesses: *CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED, IF IN DOUBT PUT A QUESTION MARK*

- ☐ Diabetes
- ☐ Cancer
- ☐ High blood pressure
- ☐ Lung disease
  Type:_____
- ☐ Sleep apnea
- ☐ Heart disease
- ☐ Chronic cough
- ☐ Chronic infection
- ☐ Thyroid disease
- ☐ Bone/Joint disease
- ☐ Serious accident
- ☐ Stroke
- ☐ Parkinson's
- ☐ PTSD
- ☐ Blood clot(s)
- ☐ Endometriosis

☐ Other: _____

Surgeries: *CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED, IF IN DOUBT PUT A QUESTION MARK*

- ☐ Appendectomy
- ☐ Bowel resection
- ☐ Gallbladder
- ☐ Hernia
- ☐ Heart surgery
- ☐ Cardiac stent(s)
- ☐ Pacemaker/Defibrillator
- ☐ Hemorrhoids

☐ Other: _____

PLEASE CONTINUE TO NEXT PAGE

HABITS: DO YOU USE? (please circle)

Tobacco/smokeless	YES	NO	Amount per day _____
# of years using tobacco	_____		Quit date? _____
Marijuana	YES	NO	Type: _____
			How much?_____ How often?_____
Alcohol	YES	NO	Drinks per day _____ Drinks per week _____
Alcohol abuse	YES	NO	Current? _____ Past? _____
Coffee	YES	NO	Cups per day _____
Tea	YES	NO	Cups per day _____
Sodas/carbonated drinks	YES	NO	Type/Amount per day _____
Gluten free diet	YES	NO	Other _____
Dairy products	YES	NO	Amount _____
Special diet	YES	NO	Amount per day _____
			Type _____

SOCIAL HISTORY

Education (circle)	High School	Vocational	College			
Type of work		Self _____		Employed	YES	NO
		Spouse _____		Employed	YES	NO
Birthplace _____		Biological gender at birth _____		Current gender identity _____		
Marital status (circle)	Single	Married	Divorced	Widowed	Domestic Partner	

Do you have religious/spiritual beliefs that would affect your decisions concerning your health care? If so, in what way?

_____

FAMILY HISTORY (circle if any family member has had the following)

Colon cancer	YES	NO	Esophageal cancer	YES	NO	Other cancer _____
Colon polyps	YES	NO	Liver disease	YES	NO	Add'l details _____
Ulcerative Colitis	YES	NO	Pancreatic cancer	YES	NO	Other diseases _____
Crohn's disease	YES	NO	Stomach cancer	YES	NO	_____

Father	Gastrointestinal illnesses _____
Mother	Gastrointestinal illnesses _____
Siblings	Gastrointestinal illnesses _____
Children	Gastrointestinal illnesses _____

Is there anything else you feel is pertinent for the provider to know about you?

_____

Patient signature _____ Date _____

Provider initials _____

DATE:

Western Washington Medical Group
Gastroenterology

PATIENT NAME: **DATE OF BIRTH:**

PHARMACY NAME **PHARMACY PHONE #**

LOCATION **PHARMACY FAX #**

Please list all medications including **over the counter medications, vitamins, antacids and herbal preparations that you are currently taking.

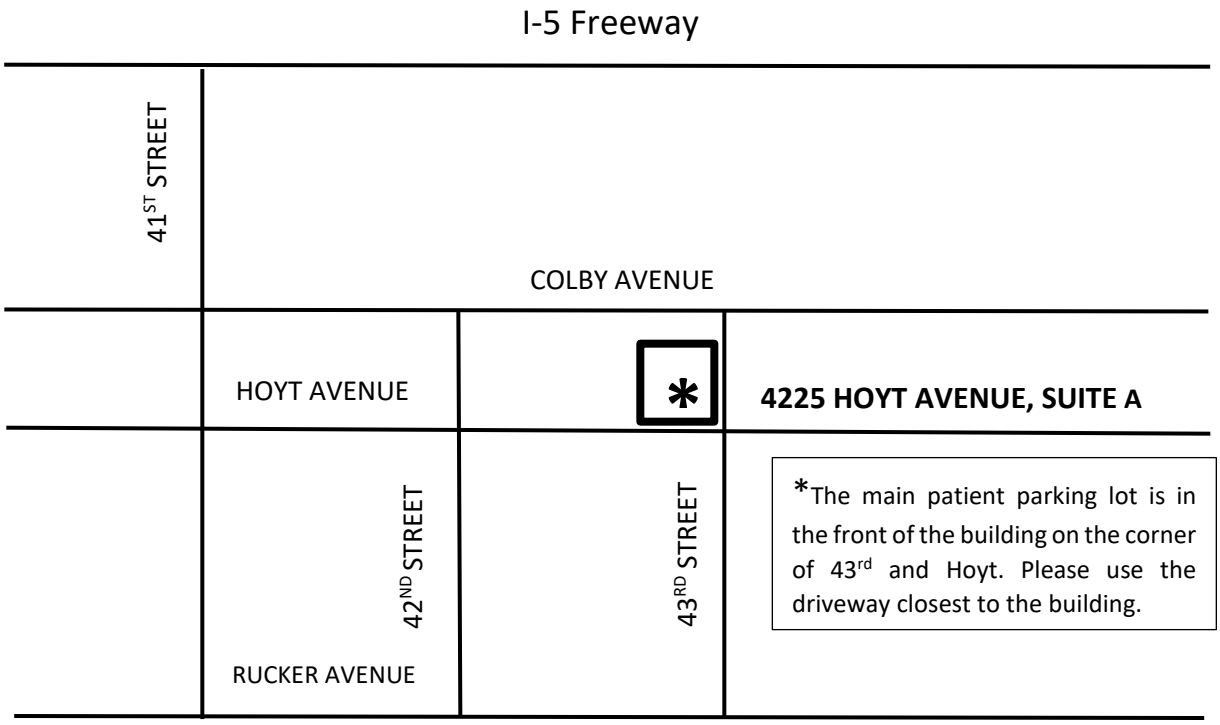
Aspirin ☐ **Ibuprofen/Advil/Aleve** ☐ **Arthritis medication** ☐

DATE STARTED	NAME OF MEDICATION, DOSE	# of times per day	PRESCRIBED BY
	EXAMPLE		
9/10/2009	**NEXIUM 40 MG**	**1 x per day**	**Dr. XYZ**

Western Washington Medical Group

Gastroenterology

4225 HOYT AVENUE, SUITE A
EVERETT, WA 98203-2318
OFFICE (425) 259-3122
FAX (425) 252-9860



4225 HOYT AVENUE, SUITE A

FROM THE NORTH:

I-5 Southbound take exit #192 to 41st Street. Bear right onto 41st Street. Continue West to Colby Avenue. Turn left onto Colby Avenue. Go two blocks to 43rd Street and take a right. Go one block and take a right onto Hoyt Avenue. Western Washington Medical Group – GI Department is on the NE corner of 43rd Street & Hoyt Avenue.

FROM THE SOUTH:

I-5 Nouthbound take exit #192 to 41st Street. Stay in the left lane on the off ramp. Turn left, heading West onto 41st Street. Continue West to Colby Avenue. Turn left onto Colby Avenue. Go two blocks to 43rd Street and take a right. Go one block and take a right onto Hoyt Avenue. Western Washington Medical Group – GI Department is on the NE corner of 43rd Street & Hoyt Avenue.