

APPOINTMENT SCHEDULED: \_\_\_\_\_ CHECK IN TIME: \_\_\_\_\_

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

**EVERETT OFFICE**

43<sup>RD</sup> & 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 19<sup>th</sup> 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.

## **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  
DEPARTMENT OF GASTROENTEROLOGY & ENDOSCOPY**

**REGISTRATION FORM**

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

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME								
DATE OF BIRTH	SEX M      F	RACE		SOCIAL SECURITY #									
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 (      )								
REFERRING DOCTOR			MARITAL STATUS										
PRIMARY CARE DOCTOR			MARRIED ____ DIVORCED ____ OTHER ____										
PHARMACY NAME/LOCATION			SINGLE ____ WIDOWED ____ SEPARATED ____										
PHARMACY NAME/LOCATION			EMAIL ADDRESS										
<b>PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED _____ OR DISABLED _____)</b>													
EMPLOYER NAME				OCCUPATION									
STREET ADDRESS			CITY	STATE	ZIP CODE								
<b>PRIMARY INSURANCE</b>													
INSURANCE COMPANY NAME			RELATION TO SUBSCRIBER		COPAY								
SUBSCRIBER'S NAME			SUBSCRIBER'S EMPLOYER										
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE ____ FEMALE ____		SUBSCRIBER'S ID #		GROUP NUMBER								
<b>SECONDARY INSURANCE</b>													
INSURANCE COMPANY NAME			RELATION TO SUBSCRIBER		COPAY								
SUBSCRIBER'S NAME			SUBSCRIBER'S EMPLOYER										
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE ____ FEMALE ____		SUBSCRIBER'S ID #		GROUP NUMBER								
EMERGENCY CONTACT (NOT LIVING WITH YOU)		NAME		RELATIONSHIP	PHONE NUMBER- HOME/WORK/CELL (      )								
<b>RESPONSIBLE PARTY</b> 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?							
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 <b>Western Washington Medical Group</b> 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 _____									
<table style="width:100%; border: none;"> <tr> <td style="border: none;">For office use only</td> <td style="border: none;">Dr. _____</td> <td style="border: none;">Ins. code _____</td> <td style="border: none;">Acct # _____</td> <td style="border: none;">initials _____</td> <td colspan="2" style="border: none;"></td> </tr> </table>							For office use only	Dr. _____	Ins. code _____	Acct # _____	initials _____		
For office use only	Dr. _____	Ins. code _____	Acct # _____	initials _____									

**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

## 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

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Chronic cough      | <input type="checkbox"/> Parkinson's   |
| <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Chronic infection  | <input type="checkbox"/> PTSD          |
| <input type="checkbox"/> Lung disease<br>Type: _____ | <input type="checkbox"/> Thyroid disease    | <input type="checkbox"/> Blood clot(s) |
| <input type="checkbox"/> Sleep apnea                 | <input type="checkbox"/> Bone/Joint disease | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Other: _____                | <input type="checkbox"/> Serious accident   |  |

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Appendectomy    | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Bowel resection | <input type="checkbox"/> Heart surgery    | <input type="checkbox"/> Hemorrhoids             |
| <input type="checkbox"/> Gallbladder     | <input type="checkbox"/> Cardiac stent(s) |  |
| <input type="checkbox"/> 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 \_\_\_\_\_



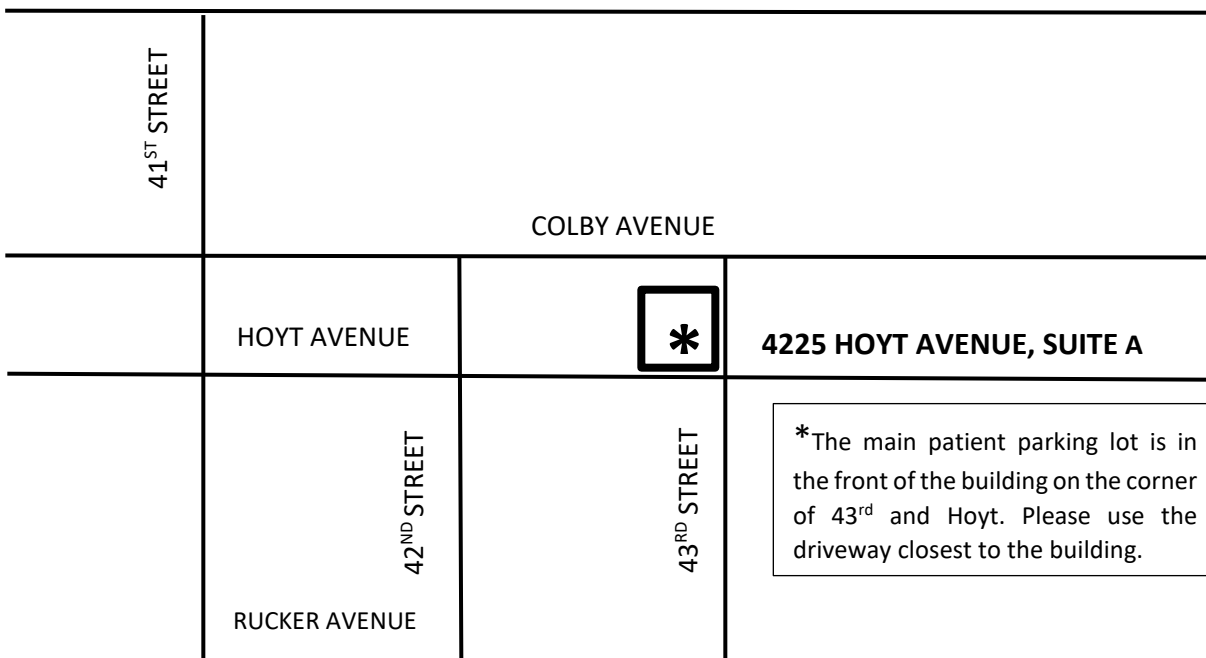


Western Washington  
Medical Group

*Gastroenterology*

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

I-5 Freeway



## **4225 HOYT AVENUE, SUITE A**

### **FROM THE NORTH:**

I-5 Southbound take exit #192 to 41<sup>st</sup> Street. Bear right onto 41<sup>st</sup> Street. Continue West to Colby Avenue. Turn left onto Colby Avenue. Go two blocks to 43<sup>rd</sup> 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 43<sup>rd</sup> Street & Hoyt Avenue.

### **FROM THE SOUTH:**

I-5 Nouthbound take exit #192 to 41<sup>st</sup> Street. Stay in the left lane on the off ramp. Turn left, heading West onto 41<sup>st</sup> Street. Continue West to Colby Avenue. Turn left onto Colby Avenue. Go two blocks to 43<sup>rd</sup> 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 43<sup>rd</sup> Street & Hoyt Avenue.