Western Washington Medical Group

Gastroenterology

Dear New Patient:

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, Washington

ENDOSCOPY CENTER
Providence Regional Mill Creek
12800 Bothell – Everett Hwy. #200
(also known as 19th Ave SE or Hwy 527)
Everett, Washington

ANACORTES
1213 24th St, Suite 700 (Island Surgeons)
Island Hospital Main Entrance

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 for you to read, fill out at your leisure at home, and **bring with you to your appointment**. Here is a checklist of the forms that are enclosed and short explanation of each:

- Blood Thinners and Cardiac Devices: We will require this for any procedure scheduling. If this does not apply to you, just leave it blank.
- Registration Form – please remember to also bring **all of your insurance cards**. We will need to scan a copy of the front and the back of the actual card(s). If **your insurance plan requires a copayment** we will collect it at the time of your visit. If your **insurance plan requires a referral** it is your responsibility to obtain one from your primary care physician, prior to this office visit. If you have difficulty obtaining the referral from your PCP please call our referral coordinator at (425) 259-3122, to see if she can assist you in any way.
- 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 verbal disclosure form.
- Medical History Form – it is extremely important to complete the form as fully as possible. This will enable us to care for you appropriately. If you require additional room, please write on a plain sheet of white paper and attach it to the History Form.
- Medications Form – please fill out this form for all the medications that you are currently taking. Please include all information about these medications such as the dosage and how often you take them. You should also include information about any herbal or over the counter medications, vitamins, minerals etc. that you take on a regular basis.
- Directions and map to the office which is highlighted above. We regularly see patients at many different locations. 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 better spent. Again, thank you for taking the time to have all of your forms ready when you arrive for your appointment. We look forward to participating in your medical care.

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 / ETHNICITY	SOCIAL SECURITY # / PREFERRED LANGUAGE

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 MARRIED ____ DIVORCED ____ OTHER ____
PRIMARY CARE DOCTOR	SINGLE ____ WIDOWED ____ SEPARATED ____
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	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___	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___	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

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, 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 #_____ initials ____

Western Washington Medical Group
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FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information.
I will rely on the professional judgment of my provider and his/her 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 chart. I, the patient, may be asked to sign a Release of Record to release WWMG to share information if my provider and his/her designee deem it necessary.

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: _____

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: _____ Cell Work Home OK to leave detailed message Y N

Second phone number: _____ Cell Work Home OK to leave detailed message Y N

Third phone number: _____ Cell Work Home OK to leave detailed message Y N

X_____
PATIENT OR GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT

X_____
PRINTED name of person signing

_____
DATE

Western Washington Medical Group

Blood Thinners and Cardiac Devices

Dear Patient:

We will require the following information in order to schedule any procedure(s) that your GI Provider may order.

For your safety, in order to schedule your procedure, we need to get a clearance to hold your Prescription Blood thinner **PRIOR** to scheduling your appointment.

If you are on one of the **following** medications please check the box below.

Name of Medications:

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

Name of Doctor/PAC/ARNP on your prescription bottle and their location/Medical Group:

_____

Device Clearance

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

We will 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.

DATE: _____

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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

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PLEASE USE BLACK INK ONLY

Please Print

MEDICAL QUESTIONNAIRE

Name _____ Date of Birth _____ Age: _____

Referring physician: _____ Primary care physician: _____

Why are you here? _____

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

_____

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

- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Food sticking
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ Ulcers
- ☐ Gastritis
- ☐ Helicobactor pylori
- ☐ Nausea/vomiting
- ☐ Stomach surgery
- ☐ Liver problems
- ☐ Alcohol abuse
- ☐ Viral hepatitis
- ☐ IV drug abuse
- ☐ Jaundice
- ☐ Gallstones
- ☐ Weight loss (last 6 mo)
- ☐ Colon polyps
- ☐ Hemorroids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Bloody bowel movement
- ☐ Black bowel movement
- ☐ Hard stools
- ☐ Soft stools

☐ Other symptoms or complaints: _____

Have you recently had a colonoscopy performed for colon cancer screening ? Yes No

Year _____ **Next surveillance due** _____

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

- ☐ Diabetes mellitus
- ☐ Cancer
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Kidney stones
- ☐ Endometriosis
- ☐ Heart disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Thyroid disease
- ☐ Other
- ☐ Serious accident
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ PTSD
- ☐ Gout

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

- ☐ Tonsils
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Gallbladder
- ☐ Heart surgery
- ☐ Other surgery
- ☐ Hernia
- ☐ Hemorrhoid

DRUG or LATEX ALLERGIES: *PLEASE LIST ANY DRUG (including LATEX) ALLERGIES THAT YOU MAY HAVE*

_____

PLEASE CONTINUE ON TO COMPLETE THE FOLLOWING TWO PAGES

HABITS DO YOU USE? (please circle)

Cigarettes Yes No Packs per day _____

Cigars Yes No Amount per day _____

Chew (snuff) Yes No Amount per day _____

# of years using tobacco _____ When did you quit? _____

Alcohol Yes No Drinks per day _____ Drinks per week _____

Alcohol problem? Yes No current in the past

Coffee Yes No Cups per day _____

Tea Yes No Cups per day _____

Diet candies Yes No Amount per day _____

Mints Yes No Amount per day _____

Chocolate Yes No Amount per day _____

Sodas or carbonated drinks Yes No Amount and type _____

Dairy products Yes No

Please give amounts of dairy _____

A specific diet Yes No Type _____

SOCIAL HISTORY

Education (circle) High School Vocational College

Type of work Self _____ Employed? Yes No

Spouse _____ Employed? Yes No

Birthplace _____ Religion _____

Marital status (circle) Single Married Divorced Widowed Domestic partner

Is your sexual partner (circle) Male Female

FAMILY HISTORY Circle if anyone in your family has had the following:

Colon cancer Yes No Abnormal bleeding Yes No Other cancer _____

Colon polyps Yes No Liver Disease Yes No Add'l details _____

Ulcerative colitis Yes No Diabetes Yes No Other diseases _____

Crohns' disease Yes No Stomach cancer Yes No _____

Father: Alive Deceased Mother: Alive Deceased

Illnesses: _____ Illnesses: _____

Brothers and Sisters: How many? _____ Illnesses: _____

Children: Sons How many? _____ Illnesses: _____

Daughters How many? _____ Illnesses: _____

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

_____

_____

Patient signature _____

Physicians initials _____ date _____

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Gastroenterology

DEPARTMENT OF GASTROENTEROLOGY
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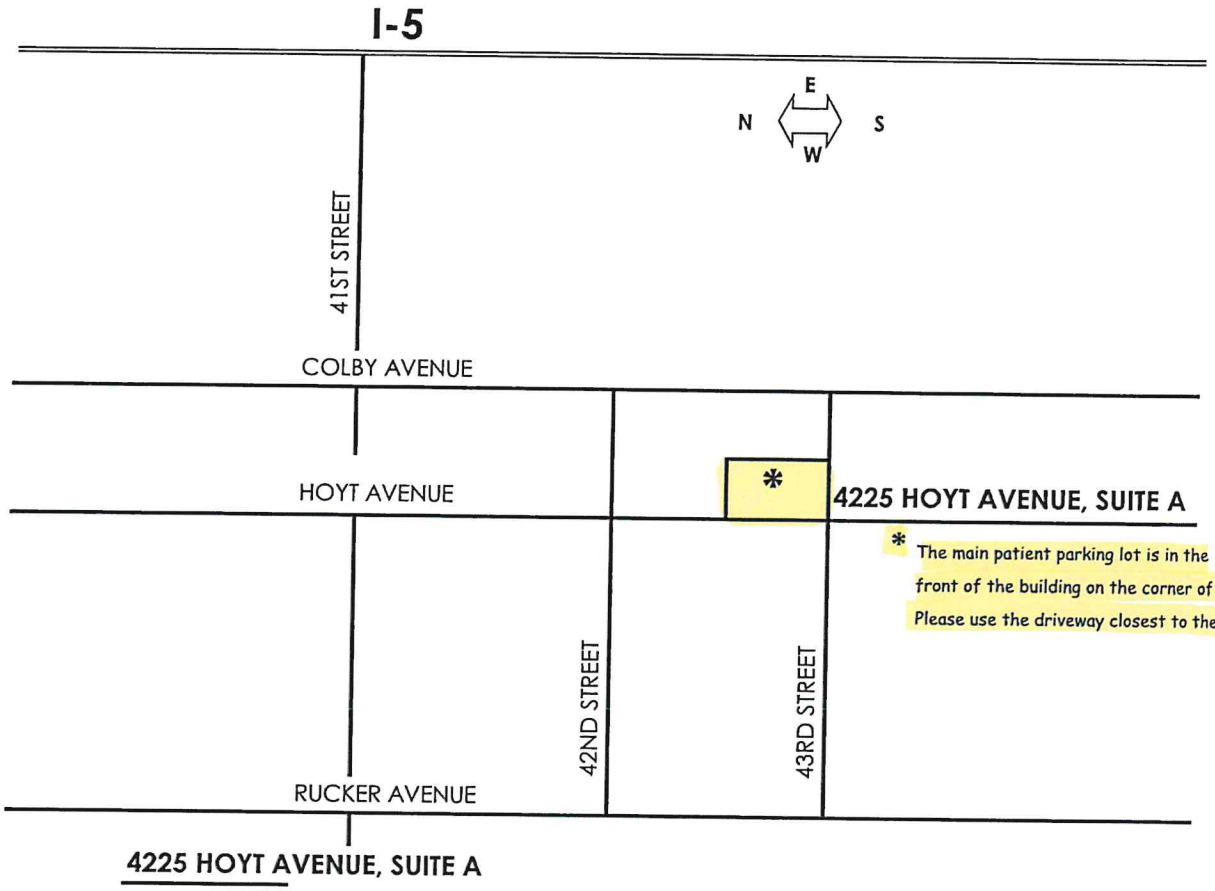

4225 HOYT AVENUE, SUITE A

FROM THE NORTH:

I-5 southbound take exit # 192 to 41st Street. Bear right onto 41st Street. Continue WEST to Colby Ave. Turn left onto Colby. 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 Dept. is on the NE corner of 43rd and Hoyt.

FROM THE SOUTH:

I-5 northbound 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. 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 Dept. is on the NE corner of 43rd and Hoyt.