

Gastroenterology

Dear New Patient:

WITH DOCTOR:

### CHECK IN TIME: PHONE: **425-259-3122 (for all offices)**

#### **EVERETT OFFICE** 43<sup>rd</sup> & Hoyt Medical Bldg. 4225 Hoyt Ave, Suite A Everett, Washington

**APPOINTMENT SCHEDULED:** 

#### **ENDOSCOPY CENTER**

Providence Regional Mill Creek 12800 Bothell – Everett Hwy. #200 (also known as 19<sup>th</sup> Ave SE or Hwy 527) Everett, Washington ANACORTES 1213 24<sup>th</sup> 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 <u>all of your insurance cards</u>. We will need to scan a copy of the front and the back of the actual card(s). If <u>your insurance plan requires a copayment</u> we will collect it at the time of your visit. If your <u>insurance plan requires a referral</u> 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 ACCOUNT#

**REGISTRATION FORM** 

STREET ADDRESS     APT #     OTY     STATE     ZIP CODE     4 DR       NOME PHONE     WORK PHONE     EXY     CELL PHONE     (, )       INFERRING DOCTOR     MARTAL STATUS     MARTAL STATUS       PRIMARY CARE DOCTOR     MARTAL STATUS     SIRUE     SIRUE     SIRUE     WORKED     SEPARATED       PRIMARY CARE DOCTOR     MARTAL STATUS     MARTAL STATUS     MARTAL STATUS     SIRUE     WORKED     SEPARATED       PRIMARY CARE DOCTOR     MARTAL STATUS     WOOKED     SEPARATED     SEPARATED     DYNORCED     OTHER       PRIMARACY NAME, PHONE NUMBER AND LOCATION     PREFERINCE EMAIL ADDRESS     OTY     STATE     ZIP CODE     4 DR       PATIENT KIMME     OCCUPATION     STATE     ZIP CODE     4 DR       STREET ADDRESS     OTY     STATE     ZIP CODE     4 DR       STREET ADDRESS     OTY     STATE     ZIP CODE     4 DR       VIBSCRIBERS DATE OF BINTH     SUBSCRIBERS SEX     COPAY     STATE     ZIP CODE     4 DR       VIBSCRIBERS DATE OF BINTH     SUBSCRIBERS SID #     GROUP NUMBER     COPAY       UBSCRIBERS DATE OF BINTH     SUBSCRIBERS SID #     GROUP NUMBER     COPAY       UBSCRIBERS DATE OF BINTH     SUBSCRIBERS SID #     GROUP NUMBER     COPAY       UBSCRIBERS DATE OF BINTH </th <th>DATE OF BIRTH       SEX       RACE       SOCIAL SECURITY #         M       F       ETHNICITY       PREFERRED LANGUAGE         MAILING ADDRESS       APT #       CITY       STATE       ZIP         STREET ADDRESS       APT #       CITY       STATE       ZIP         HOME PHONE       WORK PHONE       EXT       CELL PHONE       ()         ()       ()       MARITAL STATUS       MARITAL STATUS       OTH         PRIMARY CARE DOCTOR       MARRIED       DIVORCED       OTH         PHARMACY NAME, PHONE NUMBER AND LOCATION       PREFERRED EMAIL ADDRESS       SINGLE       WIDOWED       SEP</th> <th>CODE 4 DIGIT</th>	DATE OF BIRTH       SEX       RACE       SOCIAL SECURITY #         M       F       ETHNICITY       PREFERRED LANGUAGE         MAILING ADDRESS       APT #       CITY       STATE       ZIP         STREET ADDRESS       APT #       CITY       STATE       ZIP         HOME PHONE       WORK PHONE       EXT       CELL PHONE       ()         ()       ()       MARITAL STATUS       MARITAL STATUS       OTH         PRIMARY CARE DOCTOR       MARRIED       DIVORCED       OTH         PHARMACY NAME, PHONE NUMBER AND LOCATION       PREFERRED EMAIL ADDRESS       SINGLE       WIDOWED       SEP	CODE 4 DIGIT
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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/<u>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:	0 11		-	32 34 1		
	 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

PATIENT OR GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

PRINTED name of person signing

Х

DATE



## **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:



PATIENT NAME:

DATE OF BIRTH:

#### PHARMACY NAME

PHARMACY PHONE #

LOCATION

PHARMACY FAX #

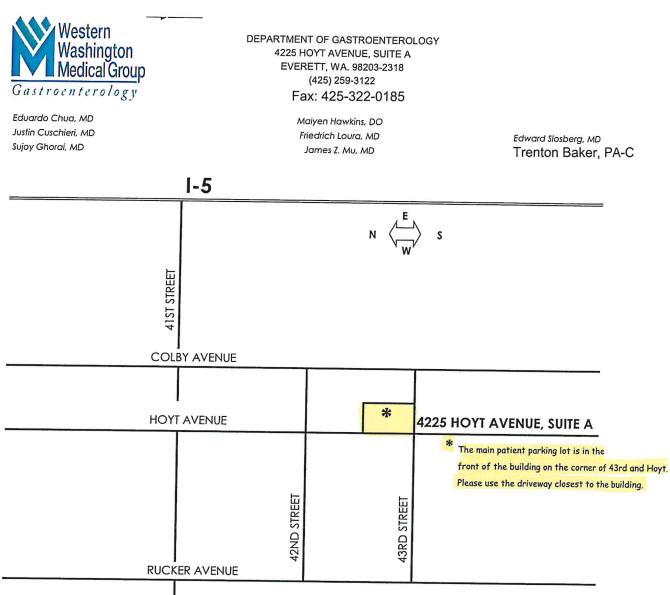
\*\*Please list all medications including over the counter medications, vitamins, antacids and herbal preparations that you are currently taking.

Aspirin	Ibuprofen/Advil/Aleve	Arthritis medica	tion
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		
Guardinerology	<u>PLEASE USE BLACK INK</u>	ONLY
<u>Please Print</u>	MEDICAL QUESTIONNAIRE	
Name	Date of Birth	Age:
Referring physician:	Primary care p	hysician:
Why are you here?		
What makes the problem beti	er or worse? What medication ha	ive you tried?
GI Review of Systems: CHECK A	NY OF THE FOLLOWING YOU HAVE HAD,	IF IN DOUBT PUT A QUESTION MARK
Difficulty swallowing	Stomach surgery	Constipation
Painful swallowing	Liver problems	Diarrhea
Food sticking	Alcohol abuse	Colon cancer
Heartburn	Viral hepatitis	Crohn's disease
Hiatal Hernia	IV drug abuse	Ulcerative colitis
Ulcers	Jaundice	Bloody bowel movement
Gastritis	Gallstones	Black bowel movement
Helicobactor pylori	Weight loss (last 6 mo)	Hard stools
Nausea/vomiting	Colon polyps	Soft stools
	Hemorroids	
Other symptoms or comp	plaints:	
Have you recently had a col	onoscopy performed for colon car	ncer screening? Yes No
Year	Next surveillance due	
Illnesses: CHECK ANY OF THE FOLLOV	VING YOU HAVE HAD, IF IN DOUBT PUT ,	A QUESTION MARK
Diabetes mellitus	Heart disease	Serious accident
Cancer	Asthma	Stroke
Hypertension	Emphysema	Rheumatic fever
HIV/AIDS	Chronic cough	PTSD
Kidney stones	Thyroid disease	Gout
Endometriosis	Other	
Surgeries: CHECK ANY OF THE FOLLOV	VING YOU HAVE HAD, IF IN DOUBT PUT ,	A QUESTION MARK
Tonsils	Gallbladder	Hernia
Appendectomy	Heart surgery	 Hemorrhoid
Hysterectomy	Other surgery	
RUG or LATEX ALLERGIES: PLEASE	LIST ANY DRUG (including LATEX ) ALL	ERGIES THAT YOU MAY HAVE

## PLEASE CONTINUE ON TO COMPLETE THE FOLLOWING TWO PAGES

HABITS DO YOU US Cigarettes		olease circ es No					
Cigars		s No	Packs per day				
Chew (snuff)			Amount per day				
		s No	Amount per day		-		
# of years using			When did you quit?				
Alcohol		s No	Drinks per day	D	rinks per	week	
Alcohol problem			current in the	past			
Coffee	Yes	s No	Cups per day				
Tea	Yes	s 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							
	Yes		Amount and type				
Dairy products		No					
Please give amou	nts o	f dairy _					
A specific diet	Yes	No	Туре				
SOCIAL HISTORY							
Education (circle)		School	Vocational Colle	ege			
Type of work	Seli					nployed? Yes No	
	ouse				– En	nployed? Yes No	
Birthplace					_ Re	ligion	
Marital status (circle	e)	Single	Married Divorced		Widowed	d Domestic partn	er
ls your sexual partne	er (cir	cle)	Male Female				
FAMILY HISTORY		Circle if a	nyone in your family has	had t	the follow	ing:	
Colon cancer	Yes	No	Abnormal bleeding	Yes	No	Other cancer	
2012 House and a second s	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: <u>Alive</u> Illnesses:		De	eceased		Mother: Illnesses	Alive	Deceased
Brothers and Sister	5.	How many	/? Illnesses:				
Children: Sons		How many					
Daughte		How many					
s there anything else t	hat y	ou feel is <sub>l</sub>	pertinent for the doctor	to kn	ow about	you?	
Patient signature							
Physicians initials							



### 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.