**Northwest Gastroenterology, PLLC**
2979 Squalicum Parkway Suite #301
Bellingham, WA 98225

**Northwest Endoscopy Center, LLC**
2930 Squalicum Parkway, Suite #202
Bellingham, WA 98225

(360) 734-1420 * FAX (360) 734-8748

## PATIENT INFORMATION

PATIENT'S NAME: ______________________________

PATIENT'S SSN: ____________ BIRTHDATE: ____/____/____ [ ] MALE [ ] FEMALE

MAILING ADDRESS: ______________________________

CITY: ____________ STATE: ______ ZIP: ________ HOME PHONE: ____________

EMAIL ADDRESS: ______________________________

EMPLOYER ____________________ WORK PHONE: ____________

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] ______ PRIMARY CARE PHYSICIAN: ____________

SPOUSE ____________________ BIRTHDATE ____/____/____

SSN ____________________ EMPLOYER ____________________

## AUTHORIZED INDIVIDUALS FOR RELEASE OF INFORMATION

Individuals authorized to receive my medical information:

____________________ ____________________

Identifier: ____________________ Identifier: ____________________

**I authorize NW Gastroenterology or NW Endoscopy Center to release information relevant to my medical history to the above individuals. To verify identity the individual may be requested to give the last 4 digits of their social security number or mother' maiden name which ever is given as identifier.**

**Dated** **Patient Signature**

## EMERGENCY CONTACT

**NAME OF RELATIVE/FRIEND: ____________________ PHONE: ( ) ____________**

(Other than spouse or significant other)

Relationship: ____________________ CELL PHONE: ( ) ____________

**RELEASE OF INFORMATION: I AUTHORIZE THE PHYSICIAN TO PROVIDE MY MEDICAL INFORMATION AS FOLLOWS:**

Labs and pharmacies need your demographic information and diagnosis code to bill your insurance. Without this information your insurance cannot be billed and you will be responsible for the bill at time of service.

- *To provide the pharmacist with my diagnosis when needed to fill prescription*
- *To provide to a laboratory or other diagnostic testing agency my diagnosis and demographic information including SS# for billing purposes*
- *To provide my primary care with results of my visit, progress notes and referral information.*
- *To provide to any physician I am referred to all medical relevant information regarding my care.*
- *To provide, when necessary for my care, the release of information related to a STD or Mental Health evaluation. [ ] Yes [ ] No*

**I AUTHORIZE THE PHYSICIAN OR A MEMBER OF HIS CLINICAL SUPPORT STAFF TO CONTACT ME AND/OR LEAVE INFORMATION AS INDICATED BELOW**. *Unless given permission, this practice will not leave information on your home or cell message machine.*

*Home Phone: ____________ MESSAGE MACHINE [ ] Yes [ ]No Work Phone: ____________ [ ] Yes [ ]No*

*Cell Phone: ____________ [ ] Yes [ ]No E-mail ____________ [ ] Yes [ ] No*

**SIGNATURE: ____________________ DATE: ____________**

This authorization is valid until ____________ as the patient you have the right to contact this practice and change your authorization for release of information at any time. This change MUST be in writing.

WITNESS: ____________________ DATE: ____________

**Northwest Gastroenterology Health History**

| Name: | Birth date: | Age: | Date: |
|---|---|---|---|
| Referring Physician: | | | |

**What problem brings you to Northwest Gastroenterology?**

| | *Please this area blank* |
|---|---|
| | |

**If you have been tested or treated for this problem please complete the following:**

| Test or type of treatment | Date | Location | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please check if you have ever had any of these illnesses:**

| | | *Please leave this area blank* |
|---|---|---|
| | Arthritis | |
| | Depression or other mental illness | |
| | Diabetes | |
| | Heart Disease | |
| | High Blood pressure | |
| | High Cholesterol or Triglycerides | |
| | Kidney Stones | |
| | Lung Disease, sleep apnea, heavy snoring | |
| | Rheumatic fever | |
| | Night Sweats, fever, chills | |
| | Thought or memory problems | |
| | Thyroid Disease | |
| | Easy bleeding and bruising | |
| | Other personal illness: | |

**Please list any past hospitalizations and *surgical* operations:**

| Mo/Yr | Reason | *Please leave this area blank* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**CURRENT MEDICATIONS: It is important for your physician to be aware of all medications you are currently taking. Please list the medications and dosage below.**

| MEDICATION AND DOSAGE | Dosage | Why are you taking medication? | When did you start? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have an allergy to latex?** [ ] Yes [ ] No

| **DRUG ALLERGIES: It is very important for your physician to be made aware of ANY drug reactions you have experienced. List all medications including across the counter.** | |
|---|---|
| **MEDICATION** | **REACTION** |
| | |
| | |
| | |
| | |
| | |

**Social habits:**

| Do you use tobacco products [ ] Yes [ ] No **If yes, please check** [ ] cigarettes [ ] cigars [ ] pipe [ ] chew | | |
|---|---|---|
| How long have you been using tobacco products: Number per day: | | |
| Do you drink alcohol? [ ] Yes [ ] No Using 2 oz of alcohol or 1 beer as a serving indicate how much you drink | per day | per week |
| Do you drink coffee? If yes how many cups per day | Do you drink black tea: If yes, how many cups per day | |
| Have you ever had a blood transfusion? [ ] Yes [ ] No | Have you ever used IV drugs? [ ] Yes [ ] No | |
| Do you have any tattoos? | | |

| **Has anyone in your family (grandparents, parents, brothers, sister, aunt, or uncles) had any of the following conditions?** Please circle | | | |
|---|---|---|---|
| Liver problems | Colon cancer | Colitis | Other Cancers, please list |

**GASTROINTESTINAL HISTORY** **do you now have or have your ever had any of the following:**

| Y | N | | ***Please leave this area blank*** |
|---|---|---|---|
| | | Difficulty chewing, swallowing/food sticking in throat | |
| | | Heartburn | |
| | | Hoarseness | |
| | | Chronic Cough | |
| | | Regurgitation | |
| | | Chest pain | |
| | | Abdominal pain | |
| | | Ulcers | |
| | | Vomiting Blood | |
| | | Fluid in Abdomen (Ascites) | |
| | | Recent change in weight (circle)<br>Gain/Loss lbs: | |
| | | Filling up quickly at meals | |
| | | Loss of Appetite | |
| | | Nausea | |
| | | Crohn's disease/Ulcerative Colitis | |
| | | Gallstones | |
| | | Prominent leg swelling | |
| | | Hepatitis/jaundice | |
| | | Pancreatitis | |
| | | Liver Problems | |
| | | Recent change in bowel movements | |
| | | Constipation | |
| | | Diarrhea | |
| | | Gastrointestinal bleeding | |
| | | Loss of control of bowel s | |
| | | Colon Cancer | |
| | | Other Cancer (list below) | |

**Patient Signature:** ____________________________________________

## INSURANCE INFORMATION

You will be asked to provide the receptionist with a copy of your insurance card. We cannot bill your insurance until we obtain this copy. Medicare patients should provide a copy of their Medicare card and supplemental insurance card if applicable.
**If you do not have the card with you please list your primary and secondary insurance companies below.** You will be asked to provide a copy of the card before we can bill your insurance. Without the card on file you will be responsible for the bill.

PRIMARY INSURANCE COMPANY: ____________________________________________

SECONDARY INSURANCE COMPANY: ____________________________________________

**Your insurance plan may require that the primary care physician initiate a referral to the specialist. It is the responsibility of the patient to ensure that this request has been completed. Your insurance company will not pay the specialist unless the referral has been authorized.**

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## NORTHWEST GASTROENTEROLOGY
### NORTHWEST ENDOSCOPY CENTER
### CREDIT POLICY

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**We have established a credit policy to avoid misunderstandings when billings are received. Please read the policy carefully, if you have any questions a member of our billing department will be happy to discuss the policy with you.**

- We bill all major commercial insurance companies, Medicare, DSHS, L&I, and Tricare. We bill primary, secondary and tertiary insurance plans.
- If you do not have insurance, payment is expected at the time of service. However we recognize that there may be times when full payment is not possible. Please contact our billing department to set up a payment plan.
- **COPAYS ARE DUE AT THE TIME OF SERVICE.** The co-pay is an agreement made between the subscriber and the insurance company. The amount of the co-pay is located on your card.
- We cannot accept responsibility for a disputed claim. If your insurance company denies the claim or withholds payment, you are ultimately responsible for the balance due.
- **PATIENT RESPONSIBILITIES**
  1. Provide NW Gastroenterology with a current copy of insurance card/coupon. This includes information on secondary and tertiary plans.
  2. If your insurance plan requires a referral from your primary care physician it is your responsibility to request the referral.
  3. To provide NW Gastroenterology with current employment information, home address and telephone numbers.
  4. Pay co-pays on day of service.
  5. Pay patient portion of bill within 30 days of receiving your statement.
  6. Contact the billing department to arrange for payment plan if there is a financial hardship.
  7. Respond in a timely manner to statements or request for payment. You will receive your first statement within 30 days of service. Follow-up statements are sent monthly.
- NW Gastroenterology will make every effort to work with you to arrange satisfactory payment of your bill. If however, payment is not received within 90 days of service and you have not contacted this office to arrange a payment plan collection activities will commence. NW Gastroenterology utilizes the services of an outside collection agency.

**RELEASE OF BENEFITS AND INFORMATION:** *I authorize the physician or insurance company to release any information for my claims. I authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I understand that NW Gastroenterology will not bill my insurance unless I provide them with a current copy of my insurance card and that unless I do so I am solely responsible for my entire bill.*

*I have read and understand the credit policy of NW Gastroenterology and agree to comply with the* ***Patient Responsibility*** *portion of the policy.*

_______________________________________________ Date_______________________

Signature of Patient