SNOQUALMIE VALLEY
HOSPITAL DISTRICT

Patient Registration

How did you hear about us? ☐ Newspaper ☐ Friend/Family ☐ Website ☐ Other: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Emergency #: _____

Birthdate: _____ SSN: _____ Sex: _____ Marital Status: _____

Ethnicity ☐ Hispanic ☐ Non-Hispanic Primary Language: _____

Employer: _____ Occupation: _____

Primary Insurance Information

Subscriber's Last Name: _____ First Name: _____ MI: ___

Address: _____

Birthdate: _____ SSN: _____ Relationship to Patient: _____

Name of Employer: _____

Name of Insurance Carrier: _____

Insurance Address: _____

Insurance #: _____ Member ID #: _____ Group #: _____

Secondary Insurance Information

Subscriber's Last Name: _____ First Name: _____ MI: ___

Address: _____

Birthdate: _____ SSN: _____ Relationship to Patient: _____

Name of Employer: _____

Name of Insurance Carrier: _____

Insurance Address: _____

Insurance #: _____ Member ID #: _____ Group #: _____

Continued on Reverse Side

Consent for Care

I consent to and authorize all medical treatments and procedures as recommended and performed by providers within Snoqualmie Valley Hospital District (SVHD). I understand I have the right to decline any specific recommended treatments.

Payment Agreement

I understand I am responsible for full payment of all charges and any co-payments are due on the day of service. I authorize the payment of benefits from my insurance to be paid directly to SVHD. I understand some or all of my health care record may be released to my insurance carrier or liable third party payer for purpose of obtaining payment for services rendered to me. If uninsured, partial payment for services is due at time services are rendered.

Privacy Practices Acknowledgment

We will not disclose your personal health information to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes these processes in detail and is available by request at any time.

_____ _____

Signature of Patient/Authorized Representative Date

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Cardiology Health History

Name: _____ Date: _____ Age: _____

Primary Care Provider: _____

Reason for Visit

_____

Medical History *(check all that apply to you and write age at time of diagnosis)*

☐ Heart Attack[414.8]
☐ Angina[414.9]
☐ High Blood Pressure[401.1]
☐ High Cholesterol[272.2]
☐ Heart Murmur
☐ Diabetes[250.00]
☐ Palpitations[785.1]
☐ Atrial Fibrillation[427.31]
☐ Heart Failure[428.22]
☐ Enlarged Heart[429.3]
☐ Stroke/TIA[434.91]
☐ Vascular Disease[440.9]
☐ Carotid Disease[433.1]

Test History *(provide most recent test date for all that apply to you)*

_____ Cardiac Echo
_____ Stress Echo
_____ Nuclear Test of the Heart
_____ Cardiac Catheterization
_____ Pacemaker Insertion
_____ Angioplasty/Stent
_____ Coronary Bypass Surgery
_____ Valve Repair/Replacement
_____ Electrophysiology Study
_____ Defibrillator Insertion

Medical Conditions *(not included above)*

_____ _____
_____ _____
_____ _____

Surgical History *(include date and reason)*

_____ _____
_____ _____

Current Medications *(include dose)*

_____ _____
_____ _____
_____ _____

Medication Allergies *(include reaction)*

_____ _____

Continued on Reverse Side

Name: _____

Social History

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____

Circle Yes (Y) or No (N)

Y N Do you drink caffeinated products? If yes, how many per day _____

Y N Do you drink alcoholic beverages? If yes, how many drinks per week _____

Y N Do you smoke cigarettes? If yes, how many packs per day _____

Y N Do you exercise regularly? If yes, how often per week _____

Current Symptoms *(check all that apply to you in the last 3 months)*

- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ Pregnant
- ☐ Blurred Vision
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Mouth Sores
- ☐ Rash
- ☐ Itching
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Swelling of Ankles
- ☐ Chronic Cough
- ☐ Spitting up Blood
- ☐ Wheezing
- ☐ Burning with Urination
- ☐ Blood in Urine
- ☐ Joint Pain or Swelling
- ☐ Back Pain
- ☐ Muscle Pain
- ☐ Headaches
- ☐ Seizures
- ☐ Strokes
- ☐ Numbness
- ☐ Memory Loss or Confusion
- ☐ Depression
- ☐ Heat or Cold Intolerance
- ☐ Excessive Thirst or Urination
- ☐ Bleeding or Bruising Tendency
- ☐ Poor Appetite
- ☐ Swallowing Difficulty
- ☐ Heartburn
- ☐ Nausea or Vomiting
- ☐ Bloating
- ☐ Belching
- ☐ Regurgitation
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Recent Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Black, Tarry Stools

Family History

Has anyone in your family had any of the following? Who? _____

☐ Heart Attack[v173] (*before age 50)* ☐ Stroke[v171] (*before age 50)* ☐ Diabetes[v180] ☐ Hypertension[v174]

Please state age and chronic medical conditions of the following blood-related family members:

Father: _____

Mother: _____

Siblings: _____

Other Concerns or Questions

_____

_____

_____

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Clinic Payment Policy

Snoqualmie Valley Hospital District (SVHD) believes that a good medical provider/patient relationship is based on good communication. We strive to provide information to our patients that clearly describe any illness, diagnosis or course of treatment. We also want to provide timely, accurate information regarding the billing arrangements we use in our practice.

Our offices are contracted with more than thirty medical insurance companies including individual, group, and HMO carriers. If you are a member of one of these plans we will bill your insurance company directly. If your insurance plan requires a co-pay or deductible for the services you receive we will collect these amounts at the time of service.

If your particular insurance plan is not one of those that we are contracted with you may still ask us to bill the company, however, insurance companies typically require that the patient pay a larger percentage of the bill if they receive services outside their contracted network. For services rendered inside or outside a particular network the co-pay is still paid at the time of service.

To determine if your insurance plan is currently contracted with SVHD please call our Clinics Billing Office at (425) 831-2310.

If you are not covered under an insurance plan you are expected to pay in full at the time of service unless payment arrangements are made prior to the service. A $75.00 pre-payment will be collected before services are rendered. Our Clinics Billing Office is open during normal business hours (8am to 5pm) and will assist in developing a payment plan if that is required.

You may be dismissed from care for a delinquent account. We are required by state and federal regulations to employ every reasonable means to collect for our service. State regulations also require that collection fees are added to the past due amount and that they be paid by the person(s) responsible for the debt.

Continued on Reverse Side

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Personal Health Information
Communication Methods

Patient Information

Name: _____ Birthdate: _____

City: _____ State: _____ Zip: _____

Permissions *(Please check ALL that apply)*

The Hospital District may leave a reminder and/or detailed message using the following methods:

☐ Home Phone: _____

☐ Work Phone: _____

☐ Cell Phone: _____

☐ Text Message: _____

☐ Email: _____

List Preferred Communication Method: _____

The Hospital District may leave a message and/or discuss my medical information with the following individual(s):

Name & Relation:_____ Phone #: _____

Name & Relation:_____ Phone #: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any of my preferences.

_____ _____

Signature of Patient/Authorized Representative Date