Snoqualmie Valley HOSPITAL
Dedicated to quality. Devoted to community.

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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Adult Health History

Name: ______________________________ Date: __________ Age: _____

□ Single □ Married □ Widowed □ Divorced

Occupation: ______________________________

Medical History *(check all that apply to you and write year of diagnosis)*

□ Abnormal Pap Smear[622.10]
□ ADD/ADHD[314.00]
□ Narcotic Addiction[304.01]
□ Alcoholism[305.00]
□ Allergies/Hay Fever[477.9]
□ Anemia[280.9]
□ Anxiety Disorder[300.00]
□ Arthritis[715.90]
□ Asthma[493.90]
□ Atrial Fibrillation[427.31]
□ Bipolar Disorder[296.8]
□ Breast Lumps[610.1]
□ B-12 Deficiency[266.2]
□ Cancer __________
□ Colon Polyps[211.3]
□ Congestive Heart Failure[428.22]
□ Depression[311]
□ Diabetes[250.00]
□ Eczema[692.9]
□ Emphysema[496]
□ Glaucoma[365.9]
□ Gout[274.9]
□ Heart Attack[414.8]
□ Hepatitis C[070.54]
□ Hernia[550.90]
□ Herniated Disc/ Back Injury[722.10]
□ Herpes 2-Genital[054.11]
□ High Blood Pressure[401.1]
□ High Cholesterol[272.2]
□ HPV-Genital Warts[078.11]
□ Irritable Bowel Syndrome[564.1]
□ Kidney Stones[592.0]
□ Migraine[346.90]
□ Osteoporosis[733.00]
□ Reflux Disease[530.81]
□ Seizure Disorder[345.90]
□ Sleep Apnea[327.23]
□ STD
□ Stroke[434.91]
□ Suicide Attempt[v62.84]
□ Thyroid Disease[244.9]
□ Ulcers/PUD[533.30]
□ Varicose Veins/ Phlebitis[454.1]
□ Other Serious Illness

Current Medications Doses

____
____
____
____
____
____
____

Medication Allergies *(include reaction):* __________ ______________________________

Hospitalizations *(include date and reason)*

____
____
____

Surgical History *(include date and reason)*

____
____
____

Gynecologic History *(women only)*

Date of last menstrual period: __________
Current birth control method: __________
How many times have you been pregnant? _____
Miscarriage: ____ Age at 1st Pregnancy: ____
Full-term Pregnancies *(>37 wks):* ____
Pre-term *(<37wks):* ____ # Abortion: ____
Ectopics: ____ # Multiple Births: ____
Living Children: ____ Year of last Pap: ______
Last Mammogram: ______ Bone Density: ______
Colonoscopy: ______ Cholesterol: _____

Immunization Status *(check and write last date)*

□ Last Tetanus *(with Pertussis Tdap)* __________
□ Gardisil/HPV Vaccine __________
□ Flu Shot __________
□ Pneumonia __________
□ Other ______________ __________

Continued on Reverse Side

Name: ______________________________

Social History

Diet Type: □ Regular □ Vegetarian/Vegan □ Restricted
Which do you routinely use: □ Helmet □ Seat Belts □ Sun Screen □ Safety Glasses

Circle Yes (Y) or No (N)

Y N Do you drink caffeine? If yes, how many drinks per day: ______
Y N Do you drink alcohol? If yes, □ Rarely □ Daily □ Weekend Only □ Want to cut Back
Y N Do/Did you use tobacco? If yes, how many packs/other per day: ______ Quit Date: ___________
Y N Do you exercise regularly? If yes, how often per week: ______
Y N Do you feel safe in your personal relationships?
Y N Are you sexually active? If yes, do you use condoms: □ Yes □ No
New partner(s) since last STI exam?_____ Want STI testing? □ Yes □ No

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] or Stroke[v171] *(before age 50)*
□ High Blood Pressure[v174]
□ Mental Illness or Suicide[v170]
□ Osteoporosis[v178.1]
□ Chemical Dependancy[305.90]
□ Alcoholism[305.00]
□ Diabetes[v180]
□ Thyroid Problems
□ Cancer ___________
Breast v163 ovarian v164.1 colon v160

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

Father: ______________________________

Mother: ______________________________

Siblings: ______________________________

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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