OLYMPIC MEDICAL PHYSICIANS
Women's Health

939 Caroline St., Level 3 East ♦ Port Angeles, WA 98362
907 Georgiana St. ♦ Port Angeles, WA 98362
840 N. 5th Avenue, Suite 1500 ♦ Sequim, WA, 98382
Phone: (360) 565-0999 ♦ **Fax:** (360) 452-7303

Welcome to Olympic Medical Physicians Women's Health

Please read this entire page to prepare you for your appointment and keep it for your information.

Complete and return paperwork ASAP and or no later than 72 hours prior to your appointment or we may have to reschedule your appointment to a later date.

Please remember to bring your photo ID, current insurance cards and co-pay with you the day of your appointment.

Please bring either a complete list or the bottles of current Medications, supplements, and any over the counter medications to your appointment.

Your children are very special and important, and are welcome at the clinic.

Our office staff cannot supervise unattended children in the waiting room.

For the safety of our pregnant patients, please do not bring a sick child to the clinic (cough, sneezes, runny nose, fever or rash).

If you have an infectious disease, please call in advance of your visit for appropriate instructions to reduce transmission to other patients.

Thank you for your assistance and consideration.

Name: _____ **Date of Birth:** _____

Date of Appointment: _____ **Time:**_____

Registration and Update Form (Confidential)

- Please complete all ➢ **Required sections** of this form then
- Provide an **Insurance Card** and **Photo ID** for copying
- If you have any questions or concerns, please ask for assistance. We will be happy to help.

OLYMPIC MEDICAL CENTER

➢ Patient Information

Last Name:_____ First Name:_____ Middle Name:_____

Social Security #:_____ Gender:_____ Date of Birth:_____

Mailing Address:_____ City:_____

State:_____ Zip:_____

Phone (Mark the best) ❑ Home:_____ ❑ Work:_____

❑ Mobile:_____ ❑ Message:_____

Aliases / Nick Name:_____ E-mail:_____

➢ General

❑ Needs Interpreter If yes; Language:_____ Religion:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated

Ethnicity: ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American
❑ Native Hawaiian/Pacific Islander ❑ White/Caucasian ❑ Other:_____

Employer:_____ Employment Status: ❑ Part Time ❑ Full Time
❑ Never Employed ❑ Not Employed ❑ Active Military Duty ❑ Disabled ❑ Retired ❑ Self Employed
❑ Student Full Time ❑ Student Part Time

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Phone_____

➢ Primary Care Doctor (Doctor, Nurse Practitioner, Physicians Assistant, etc.)

Dr. Name:_____ Phone:_____

➢ Patient Emergency Contacts-At least 1 immediate family member

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

➢ Financially Responsible Party (Guarantor) (Complete if Guarantor is the parent or anyone other than the patient)

Guarantor Name:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Social Security #:_____ Gender:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Employer:_____ Employment Status: ❑ Part Time ❑ Full Time
❑ Never Employed ❑ Not Employed ❑ Active Military Duty ❑ Disabled ❑ Retired ❑ Self Employed
❑ Student Full Time ❑ Student Part Time

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Phone:_____

➢ Coverage Information

Primary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship:_____

Address:_____ City: _____ State:_____ Zip:_____

Secondary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship_____

Address:_____ City: _____ State_____ Zip:_____

➢ Advanced Directives

Do you have any Advanced Directives? ❑ Yes ❑ No

Last Name: _____ First Name: _____ Date of Birth: _____

By providing the following information, you enable us to give quality care that meets your unique needs.
Your answers to these questions are confidential, but will become a part of your medical record.

OLYMPIC MEDICAL PHYSICIANS
Women's Health

ALLERGIES

Please list all Medications, Foods and Environmental Factors to which you react

What caused the allergy?	Reaction

MEDICATIONS

What is the name of your preferred pharmacy? _____

Please list any medications you have taken since conceiving, including vitamins and supplements

Medication	Date Started	Dose	Frequency	Reason for taking

OBSTETRICAL HISTORY

Please list your pregnancies in order by date

Date	Type: Term, Preterm, Stillbirth, Ectopic, Miscarriage or Abortion	Length of Pregnancy (weeks)	Length of Labor (hours)	Weight	Sex	Vaginal Delivery or C-Section	Type of Pain control	Place of Delivery	Name of Midwife or Doctor
Complications:									
Complications:									
Complications:									
Complications:									
Complications:									

Last Name: _____ First Name: _____ Date of Birth: _____

GYNECOLOGICAL HISTORY

1. What was the first day of your last menstrual period? _____ How often are your periods? _____
   Do you consider your periods to be abnormal? Please describe: _____
2. When was your last pap smear? _____ Result: _____
   Where was this done? _____
3. Are you sexually active? ❑ Yes ❑ No With whom? ❑ Male(s) ❑ Female(s) ❑ Both
4. Are you using birth control? ❑ Yes ❑ No If so, what are you using? _____
5. Are you hoping to become pregnant soon? ❑ Yes ❑ No

MEDICAL HISTORY

Please note any of the following that pertain to your personal medical history

Year	Medical Problem / Diagnosis	Details of Condition and Treatment
	Abnormal Pap	
	Anemia	
	Anesthetic complications	
	Asthma	
	Autoimmune disorders (lupus, eczema, arthritis)	
	Blood or clotting disorder	
	Blood transfusion	
	Breast Problems	
	Cancer	
	Chicken Pox or Varicella Vaccine	
	Diabetes	
	Drug or Alcohol use requiring treatment	
	IV drug use or a sexual partner who has used IV drugs	
	Gynecologic problems (fibroids, endometriosis, etc…)	
	Heart Problems	
	High blood pressure	
	HIV/AIDS	
	Sexually-transmitted infections (chlamydia, gonorrhea, herpes, syphilis, HPV)	
	Infertility	
	Kidney or urinary tract problems	
	Liver disease	
	Mental health problems (Depression, anxiety, bipolar)	
	Rh incompatibility	
	Seizures	
	Thyroid disease	
	Trauma / violence / abuse	
	Tuberculosis	
	Varicosities / Phlebitis	
	Other:	

Last Name: _____ First Name: _____ Date of Birth: _____

FAMILY HISTORY

Adopted: ❑ No ❑ Yes Family history unknown: ❑ No ❑ Yes

Relation	Name	Living or Deceased	Relation	Name	Living or Deceased
Mother			❑ Brother ❑ Sister		
Father			❑ Brother ❑ Sister		
❑ Brother ❑ Sister			❑ Brother ❑ Sister		

Please mark if you have any relatives with the following

Key: MGM = Maternal (mother's side) Grandmother; MGF = Maternal Grandfather; PGM = Paternal (father's side) Grandmother; PGF = Paternal Grandfather

Condition	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Other
Cancer									
Diabetes									
High Blood Pressure									
Three or more Miscarriages									
Stroke									
Rheumatoid arthritis									
Osteoarthritis									
Asthma									
Heart Failure									
High Cholesterol									
Migraines									
Rashes / skin problems									
Seizures									
Thyroid Disease									

SURGICAL HISTORY

Please list any non-obstetric surgeries or hospitalizations, when they occurred, and where you were treated

Year	Reason for Hospitalization and/or type of Operation	Hospital and Location

Last Name: _____ First Name: _____ Date of Birth: _____

SOCIAL SCREENING

1. What is your occupation? _____
2. Who do you live with? _____
3. How often do you exercise?_____
4. Do you wear a seatbelt when traveling by car? _____
5. Do you feel safe in your current relationship? ❑ Yes ❑ No _____
6. Have you ever been hit, slapped, physically hurt or threatened by a partner? ❑ No ❑ Yes
   _____
7. Is anyone in your life misusing your money or property? ❑ No ❑ Yes

Please note any past or present substance use:

Substance	**Never**	**Former User**	**Daily (# per day)**	**Once a Week**	**Once a Month**	**Start Date**	**Quit Date**
Cigarettes							
E-Cigarettes							
Second-Hand Smoke							
Chewing Tobacco							
Alcohol							
Sleep Medications							
Narcotic Pain Medications (opioids)							
Anxiety Medications							
Marijuana							
Crack or Cocaine							
Methamphetamine							
Heroin or Methadone							

Thank you!

OLYMPIC
MEDICAL PHYSICIANS

PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION

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PATIENT INFORMATION

Patient Name (printed):_____ Previous Name(s):_____

Date of Birth:_____ Daytime Telephone Number:_____

INFORMATION TO BE RELEASED FROM:

I hereby authorize Olympic Medical Physicians Clinics to release the following information contained in my medical record and/or information regarding my medical care or condition as described in detail below.

INFORMATION TO BE RELEASED TO:

Name:_____

Relationship:_____ Phone Number:_____

Name:_____

Relationship:_____ Phone Number:_____

Name:_____

Relationship:_____ Phone Number:_____

GENERAL INFORMATION TO BE RELEASED

❑ You may release test results and appointment information to the above named person(s)

❑ You may discuss my medical condition(s) and/or current treatment with the above named person(s)

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

_____ Drug and Alcohol Abuse/Treatment

_____ Mental Health/Psychiatric Disorders

_____ HIV/AIDS Virus

_____ Sexually Transmitted Diseases

CONSENT TO DISCLOSE

By my signature below I indicate that I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization will be valid until:_____

Date	Signature of patient or representative	Relationship to patient

FOR FACILITY USE ONLY

Date Received:_____ Date Information Released:_____ Chart #:_____

Person/Department Sending Records: _____

❑ Faxed ❑ Mailed ❑ Picked Up:_____ ❑ Other:_____

OLYMPIC MEDICAL CENTER

Financial Assistance
Plain Language Summary

Olympic Medical Center is committed to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. Olympic Medical Center's Financial Assistance Program provides financial assistance for qualifying patients who need help paying for emergency or medically necessary care they receive in an Olympic Medical Center facility or by an Olympic Medical Center provider.

Who is eligible for Financial Assistance and what are the requirements?
The program helps uninsured or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for Financial Assistance when their Family Income is at or below 300% of the Federal Poverty Guidelines (FPG). Evaluation of other criteria may be required. Patients should consult with a Patient Financial Service Representative at 360-417-7111 to determine eligibility and for assistance applying. Patients who have experienced a catastrophic event may be eligible under special circumstances, regardless of household income.

What does the program cover?
The Financial Assistance Program covers medically necessary care provided at an Olympic Medical Center facility or by an Olympic Medical Center provider.

Is there language assistance?
Interpreters are available to you at no cost. The Financial Assistance application, policy, and this policy summary may be available in your language. For more information please call 360-417-7111.

How do I apply?
For a free copy of the entire Financial Assistance Policy and/or an Application for Financial Assistance:

- Visit www.olympicmedical.org, then go to Patients & Visitors, Billing & Financial Services
- Visit the Patient Financial Services Department at 519 S Peabody, Port Angeles, WA 98362. Office hours are Monday-Friday 8:00 AM to 4:30 PM.
- Send a request by mail to: Olympic Medical Center, 519 S Peabody, Port Angeles, WA 98362
- Call Patient Financial Services at (360) 417-7111 or (800) 854-2844

Please mail the completed applications, including all required documentation and information specified in the application instructions to:

Olympic Medical Center, 519 S Peabody St., Port Angeles, WA 98362

We are able to process submitted applications only once they are complete, and will determine whether you are eligible according to the Olympic Medical Center Financial Assistance Policy. We will not consider incomplete applications, but will notify applicants and provide an opportunity to send the missing documentation or information by the required deadline.

For additional information, please contact Patient Financial Services:

Phone:
(360) 417-7111
(800) 854-2844

In Person:
519 S Peabody St.
Port Angeles
Monday - Friday
8:00am to 4:30pm

Mail:
939 Caroline St.
Port Angeles, WA 98362

OLYMPIC MEDICAL CENTER

Financial Assistance Sliding Scale 2017

Gross Monthly Income					
Family Size	**100% Discount (100% FPG)**	**80% Discount (125% FPG)**	**60% Discount (150% FPG)**	**45% Discount (200% FPG)**	**30% Discount (300% FPG)**
1	0-1,005	1,006-1,257	1,258 - 1,508	1,509 - 2,010	2,011 - 3,015
2	0-1,354	1,355-1,692	1,693 - 2,030	2,031-2,708	2,709 - 4,060
3	0-1,702	1,703-2,128	2,129 - 2,553	2,554 - 3,404	3,405 - 5,105
4	0-2,050	2,051-2,563	2,564 - 3,075	3,076 - 4,100	4,101 - 6,150
5	0-2,399	2,400 - 2,998	2,999 - 3,598	3,599 - 4,797	4,798 - 7,195
6	0-2,747	2,748 -3,434	3,435 - 4,120	4,121 - 5,494	5,495 - 8,240
7	0-3,095	3,096 - 3,869	3,870 - 4,643	4,644 - 6,190	6,191 - 9,285
8	0-3,444	3,445 - 4,305	4,306 - 5,165	5,166 - 6,887	6,888 - 10,330

Gross Annual Income					
Family Size	**100% Discount (100% FPG)**	**80% Discount (125% FPG)**	**60% Discount (150% FPG)**	**45% Discount (200% FPG)**	**30% Discount (300% FPG)**
1	0-12,060	12,061-15,075	15,076-18,090	18,091-24,120	24,121-36,180
2	0-16,240	16,241-20,300	20,301-24,360	24,361-32,480	32,481-48,720
3	0-20,420	20,421-25,525	25,526-30,630	30,631-40,840	40,841-61,260
4	0-24,600	24,601-30,750	30,751-36,900	36,901-49,200	49,201-73,800
5	0-28,780	28,781-35,975	35,976-43,170	43,171-57,560	57,561-86,340
6	0-32,960	32,961-41,200	41,201-49,440	49,441-65,920	65,921-98,880
7	0-37,140	37,141-46,425	46,426-55,710	55,711-74,280	74,281-111,420
8	0-41,320	41,321-51,650	51,651-61,980	61,981-82,640	82,641-123,960

Due to yearly updates to this information, there may be a more recent version.
The latest version will be posted on our website:
www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services