BELLINGHAM OSTEOPATHIC CENTER, PC
Patient Registration

Patient Information:

First Name: _____ Middle Int._____ Last Name: _____

Age: _____ Date of Birth: _____ Sex: F / M Height: _____ Weight: _____

Marital Status: Single Married Divorced Widowed Last BP reading _____ Date of reading_____

Race: White Black/African American Asian Pacific Islander American Indian Hispanic/Latino Not provided

Address:_____
(Street) (City) (State) (Zip)
Phone (Home): _____ (Cell): _____(Work): _____

Email: _____

Emergency Contact Name: _____Relationship: _____Phone: _____

Education level: High School _____ Trade School _____ Some College _____ Bachelor's Degree _____
Master's Degree _____Doctoral Degree_____ Veteran: _____ Branch of Military_____

Occupation: _____Employer_____

Status of Employment: Full Time_____ Part Time _____ Unemployed _____ Retired _____ Homemaker _____ Military _____

Social Security #_____-_____-_____

Person Responsible for Payment:

Name: _____Relationship: _____Phone: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Insurance Information:

Insurance Carrier: _____ Phone : _____

Policy Holder Name: _____Date of Birth: _____

Member ID #: _____ Group #: _____

Secondary: Yes/ NO

Insurance Carrier: _____ ID #_____

Policy Holder Name: _____Date of Birth: _____

Reason for Today's Visit:

_____

How did it start and the date of on-set?

_____

Referred by / How did you hear about us:

_____

I request that payment of authorized insurance benefits be made on my behalf to Bellingham Osteopathic Center. I authorize any holder of medical or other information about me to be released to my insurance company and its agents if information is needed to determine these benefits or benefits for related services. I accept full responsibility for services rendered as I consent for medical treatment and have verified the insurance listed on this slip to be accurate.

I understand that this information will remain confidential and will not be transferred to outside entities without my written consent. I also have received and understand the policies outlined in HIPAA summary "Notice of Privacy Practices".

Patient/Guardian Signature: _____ Date: _____

BELLINGHAM OSTEOPATHIC CENTER, PC

Health History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

MEDICATIONS: Please list all medications you are currently taking

Name of Medication: Dosage: Purpose: Prescriber:

_____
_____
_____
_____
_____
_____

*__Allergies to Medication/Other:__ Please list any reactions you have to medications, foods, the environment, or chemical

_____
_____
_____

VACCINATIONS: COVID-19 vaccine date _____ Pneumonia vaccine date _____ Influenza vaccine date _____
Other: _____

FAMILY HISTORY: Describe conditions/illness of family members

	Age	Gender	Health Status	Death/Cause/Age
Father:				
Mother:				
Siblings:				
Children:				

Family History for All Blood Relatives:

Cancer_____ Allergies _____ Headaches_____ Diabetes_____ Hypertension_____ Kidney disease_____
Gallbladder disease_____ Weight issues_____ Structural issues _____ Substance abuse_____
Other_____

ALL CURRENT PHYSICIANS, PRACTITIONERS, AND THERAPISTS, and the reason for treatment:

_____
_____
_____
_____
_____

DIAGNOSTIC TESTS: **Dates** **Body Area** **Results**

X-Ray: _____
CAT Scan: _____
MRI: _____
Bone Density: _____
EMG: _____
EEG: _____
Labs: _____
Other**:** _____

	Better	Worse	No Change
Heat:	_____	_____	_____
Ice:	_____	_____	_____
Rest:	_____	_____	_____
Sitting:	_____	_____	_____
Standing:	_____	_____	_____
Activity:	_____	_____	_____
Exercise:	_____	_____	_____
Stretching:	_____	_____	_____
Strengthening:	_____	_____	_____
Massage:	_____	_____	_____
PT/OT:	_____	_____	_____
Osteopathic Treatment:	_____	_____	_____

	Better	Worse	No Change
Chiropractic:	_____	_____	_____
Braces:	_____	_____	_____
Orthotics/Lifts:	_____	_____	_____
Injections:	_____	_____	_____
Surgery:	_____	_____	_____
Acupuncture:	_____	_____	_____
Counseling:	_____	_____	_____
Biofeedback:	_____	_____	_____
Anti-Inflammatory:	_____	_____	_____
Muscle relaxant:	_____	_____	_____
Narcotics:	_____	_____	_____
Antidepressant:	_____	_____	_____

Other: _____

MEDICAL HISTORY: Please check any of the following diagnosed illnesses or conditions that you have had.

SYSTEMIC ILLNESSES:
- ☐ Measles
- ☐ Chickenpox
- ☐ Whooping cough
- ☐ Staph/strep infection
- ☐ Sepsis
- ☐ Meningitis
- ☐ HIV
- ☐ Ehlers Danlos
- ☐ EBV
- ☐ Lyme
- ☐ Cancer

NEUROLOGICAL SYSTEM:
- ☐ Headaches/Migraine
- ☐ Epilepsy
- ☐ Dizziness/vertigo

MENTAL FUNCTION:
- ☐ Depression
- ☐ Anxiety
- ☐ Dementia
- ☐ Alzheimer's
- ☐ ADHD

MUSCULOSKELETAL SYSTEM:
- ☐ Scoliosis,
- ☐ Spinal pain,
- ☐ Osteoarthritis,
- ☐ Rheumatoid arthritis,
- ☐ Gout,
- ☐ SLE (lupus)
- ☐ Knee/Hip/Shoulder problems,
- ☐ Ankle sprains
- ☐ Fibromyalgia
- ☐ Carpal tunnel

DERMATOLOGICAL SYSTEM:
- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Eczema
- ☐ Melanoma,
- ☐ EYES:
- ☐ Vision problems
- ☐ Glaucoma,
- ☐ Macular degeneration

ENT:
- ☐ Sinusitis
- ☐ Allergies
- ☐ Ear infection
- ☐ Tinnitus
- ☐ Thyroid disease
- ☐ Trigeminal Neuralgia
- ☐ Meniere's

CARDIAC:
- ☐ Hypertension
- ☐ Hyper-cholesterol
- ☐ CHF
- ☐ MI
- ☐ CAD
- ☐ Stroke
- ☐ Anemia

RESPIRATORY:
- ☐ Pneumonia
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis
- ☐ Sinusitis
- ☐ Tuberculosis

GASTROINTESTINAL SYSTEM:
- ☐ GI ulcer
- ☐ GERD
- ☐ Hepatitis
- ☐ IBS
- ☐ Diabetes

GENITOURINARY SYSTEM:
- ☐ Pyelonephritis
- ☐ Kidney stones
- ☐ Renal failure
- ☐ Interstitial cystitis

MEN:
- ☐ BPH
- ☐ Prostate cancer
- ☐ ED
- ☐ Infertility
- ☐ Number of Children _____

WOMEN:
- ☐ PMS
- ☐ Hot flashes
- ☐ Infertility
- ☐ Miscarriages
- ☐ Breast cancer
- ☐ Menstrual difficulties
- ☐ Number of Children _____

SURGICAL HISTORY: NONE: ____

Disc/Laminectomy ____ Fracture repair _____ Ligament repair _____ Torn cartilage _____ Scoliosis ____
Spinal fusion _____ Joint repair/replacement _____ C-Section _____ Gallbladder _____ Appendix _____ Prostate _____
Breast ____ Sinus _____ Ear _____ Nose _____ Tonsils/adenoids _____ Dental _____ Angioplasty _____ Bypass ____
Laparoscopic procedures _____ Cosmetic _____ Other_____

TRAUMA HISTORY: NONE: ___

Head trauma/concussion: _____
Motor vehicle accidents: _____
Injuries (sports, falls, etc.): _____
Physically demanding activities (sport/arts/crafts etc.): _____
Dental work (extractions, braces, etc.): _____
Injuries from giving birth: _____
Injuries during your birth: _____
Emotional trauma: _____
Any hospitalizations: _____
Other: _____

LIFESTYLE HISTORY: Please check any that apply to you and answer blanks where appropriate

Relationship Status: Single___ Married___ Partnered____ Separated____ Divorced____ Widow/er____ Other_____
Who lives in your home: _____
Quality of Home Life: _____
Life Stressors: Change in Family Dynamic____ Medical Issues____ Financial Hardship_____ Job Change or Loss_____
Loss of Loved One____ Loss of Relationship____ New Relationship____ Moving____ Recent Marriage____
Recent pregnancy____
Pregnancies: Number____ Term____ Premature____ Abortions/Miscarriages____ Living____
Job title/Duties/ Physical demands: _____
Environmental exposures (including smokers, pets): _____NONE: _____
Exposure History: Mold____ Lead____ Well Water____ Radiation____ Toxic Chemicals _____Toxic Biological____
Other_____

HABITS:

Smoking: Never_____ Previously_____ Currently_____ Amount per day_____
Alcohol: Never_____ Occasionally_____ Socially_____ Daily_____ Type_____ Drinks per week_____
Drugs: Cannabis (CBD/THC) _____ Stimulants_____ Psychoactive pharmaceuticals_____ Street drugs_____
Caffeine: Coffee_____ Tea_____ Soda_____ Energy Drinks; Amount per day_____

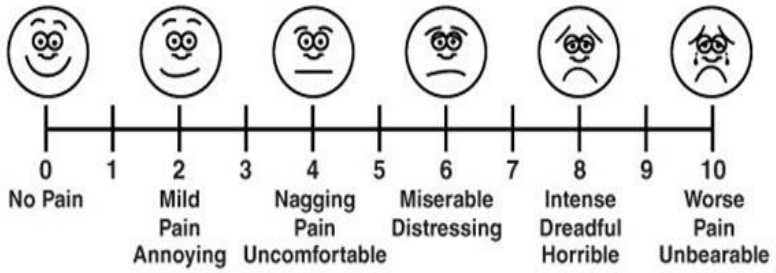
HEALTH MAINTENANCE:

Physical activity (type/frequency): _____
Stretching (type/frequency): _____
Hobbies/Recreation (type/frequency): _____
Dietary Habits: Regular_____ Vegetarian_____ Vegan_____ Diabetic_____ Gluten Free_____ Dairy Free_____
Low Fat_____ Low Calorie_____ High Fiber_____ Low Fiber_____
Fluid intake (type, amount/day): _____
Sleep/Rest (hours/day, quality): _____
Vision: Legally Blind___ Reading Glasses___ Prescription Glasses/Contacts___; Approx. date of last Vision Exam ____
Hearing: Hearing Aids_____ Deafness_____ Tinnitus_____; Approx. date of last hearing Exam _____
Dental: Daily Brushing_____ Daily Flossing_____ Dentures/Partials_____; Approx. date of last cleaning_____
Home Safety Issues____ Fall in the Last Year_____ Gait Issues_____ Strength Issues_____ Postural Hypotension____

CURRENT COMPLAINTS/PAIN:

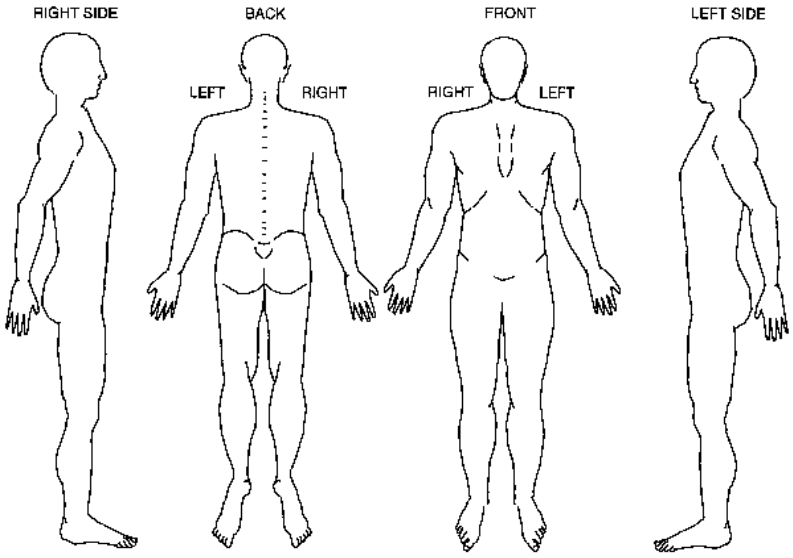
Please describe location/symptoms/onset dates of each complaint: _____
Causes: MVA_____ Work injury_____ Computer use_____ Fall_____ Bend_____ Twist_____ Lift_____ Push/Pull____
Sport injury_____ Other trauma_____ Allergy_____ Infection_____ Unknown_____ Other_____
Does your pain radiate or move to another part of your body? Yes or No; _____
Did the pain/complaint start suddenly or slowly? _____
Have your pain/complaints changed since they started? _____
Have you had any numbness/tingling, swelling, weakness or paralysis in limbs or elsewhere?
_____
Are your pains/complaint worse with certain movements? Explain: _____
Are you pain/complaints present all the time, or do they come and go? _____
Are your pains/complaints present continuously, or intermittently? _____
Are your pains/complaints worse with certain movements or activities? _____
Do your pains/complaints affect any of the following: daily activities____ sleep____ work_____ personal care_____
Does your work require prolonged standing or sitting: _____
Have you recently started a new sport, exercise program or manual labor? _____
Please circle any of the following that apply to your complaints/pain: swelling, fever, weight change, rash, visual changes, chest, pain, nausea, vomiting

PAIN/ COMPLAINT DRAWING AND SCALE: Please indicate level and locations:



PAIN LOCATION: Please draw the location and type of pain on the body outlined below, using these below:

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
///////////	BBBBBBB	XXXXXXXX	- - - - - - - - - - - -	SSSSSSSSS



BELLINGHAM OSTEOPATHIC CENTER, PC

REVIEW OF SYSTEMS: (Please Check or Circle ALL that you have ever had)

GENERAL:
- ☐ Weight gain or loss
- ☐ Change in appetite/thirst
- ☐ Fatigue, weakness
- ☐ Change in sleep pattern
- ☐ Fever, chills, night sweats
- ☐ Heat/Cold intolerance
- ☐ Decline in health

HEAD, EYES, EARS, NOSE, THROAT & MOUTH:
- ☐ Eye pain/disease, visual problems
  Ear pain/infections/ringing, hearing problems
- ☐ Chronic sinusitis, nasal discharge
- ☐ Sore throat, change in voice
- ☐ Difficulty swallowing

SKIN:
- ☐ Itching, burning, rashes (psoriasis, eczema)
- ☐ Lumps, tumors, cancer
- ☐ Changes in moles/warts/lesions

PSYCHOLOGICAL:
- ☐ Behavioral change, Mood changes
- ☐ Psychiatric disorders
- ☐ Often nervous/worried
- ☐ Post-traumatic stress disorder
- ☐ Constant feelings of sadness or hopelessness
- ☐ Hospitalized for mental illness
- ☐ Disturbing thoughts
- ☐ Hallucinations
- ☐ Thoughts of self-harm or wishing to be dead
- ☐ Depression – on a scale of 0-9 _____

NERVOUS SYSTEM:
- ☐ Seizures, tremors
- ☐ Headache
- ☐ Numbness, tingling, burning,
- ☐ Loss of coordination, unsteady gait
- ☐ Dizziness/Vertigo
- ☐ Blackouts, Fainting
- ☐ Loss of consciousness, head injury
- ☐ Paralysis
- ☐ Memory loss
- ☐ Speech disorders
- ☐ Stroke

CARDIOVASCULAR:
- ☐ Chest pain, heart attack, angina
- ☐ Palpitations, arrhythmia, heart murmurs
- ☐ Blood vessel disease, clots, thrombophlebitis
- ☐ Foot/Ankle swelling
- ☐ Heart failure
- ☐ High blood pressure

RESPIRATORY:
- ☐ Wheeze, asthma, use of inhalers
- ☐ Shortness of breath – with activity/at rest
- ☐ Frequent cough, bronchitis, COPD
- ☐ Pneumonia, flu, RSV

GASTROINTESTINAL:
- ☐ Nausea/Vomiting
- ☐ Abdominal pain, ulcer
- ☐ Heartburn, reflux, hiatal hernia
- ☐ Change in bowel habits: freq., color, consistency
- ☐ IBD/IBS: Crohn's, Ulc. Colitis
- ☐ Excessive gas, food intol.
- ☐ Liver/Gallbladder disease

URINARY:
- ☐ Sexually transmitted diseases
- ☐ Frequent UTI, pain w/urinating
- ☐ Incontinence or difficulty urinating
- ☐ Kidney stones, tumors, procedures

HEMATOLOGIC/LYMPHATIC:
- ☐ Anemia
- ☐ Easy bruisability, bleeding easily
- ☐ Lumps
- ☐ Transfusion reaction
- ☐ Blood clots

MUSCULOSKELETAL SYSTEM:
- ☐ Joint pain, redness, swelling, stiffness
- ☐ Frequent/severe muscle pain/weakness
- ☐ Disc herniation
- ☐ Short leg syndrome
- ☐ Abnormal curvature of the spine
- ☐ Worker's Comp injuries

FEMALE ENDOCRINE/REPRODUCTIVE:
- ☐ Sexual dysfunction: decreased desire, pain
- ☐ Menstrual irregularity: flow, bloating, PMS
- ☐ Endometriosis, fibroids
- ☐ Infertility, miscarriages
- ☐ Menopausal, Peri-Menopausal
- ☐ Breast lumps/cysts/tumors, nipple discharge
- ☐ Osteopenia/osteoporosis

MALE ENDOCRINE/REPRODUCTIVE:
- ☐ Erectile Dysfunction
- ☐ Sexual dysfunction: desire, pain, infertility
- ☐ Loss of muscle mass, strength
- ☐ Prostate disease

OTHER PROBLEMS (not above):

_____

BELLINGHAM OSTEOPATHIC CENTER, PC
Office Policies

Welcome!

Please review this information carefully and sign below.

At Bellingham Osteopathic Center**, Dr. Sharon Stanley, DO is considered a specialist in traditional osteopathy and classical homeopathy, not as a primary care provider**. This may affect copayment amounts and the need for a referral. We recommend all patients have a primary care physician for their primary care needs and for referrals. Dr. Stanley, DO treats all ages and all conditions within the context of her specialty, Neuromuscular Medicine, and Osteopathic Manipulative Medicine (OMM or OMT).

INSURANCE:
Bellingham Osteopathic Center is contracted with most major insurance plans. All questions regarding details of your specific plan and coverage should be directed to your insurance carrier. It is the patient's responsibility to update new or modified insurance information with our office prior to your visit, as well as provide us with a copy of your most recently issued insurance cards. T**he patient is responsible for getting a specialty referral, if required by their insurance plan.** We do not bill the following insurance: Workman's Compensation, Medicaid (Apple, Molina, Including Medicaid MCO's), Disability Insurance and Personal Injury Liens. **We are not a Medicaid provider!**
Dr. Sharon Stanley, DO does not participate in depositions, court testimony on a patient's behalf or as expert witnesses unless previous arrangements have been made with the attorney.

ASSIGNMENT OF BENEFITS:

_____ (Initial) I authorize Bellingham Osteopathic Center to bill my insurance for services rendered and agree to pay the balance assigned to patient responsibility by my insurance company, as well as any non-covered charges.

Insurance companies will send you an EOB (Explanation of Benefits) that describes coverage amounts including non-covered charges, patient responsibility including but not limited to copayment and coinsurance, as well as specific adjustments, and deductible applications. Please contact your insurance company for specific questions regarding your plan, coverage, referral requirements and explanation of benefits.

PAYMENTS AND BILLING:
All copayments and outstanding balances are due at the time of service unless previous arrangements have been made. We accept all major credit cards, personal checks, and cash. Monthly billing statements are generated as required for outstanding balances. If insurance payments are delayed or processed incorrectly, billing statements will be adjusted accordingly.

PLEASE REMEMBER ONCE A CLAIM IS SUBMITTED TO AN INSURANCE COMPANY, ANY ASSIGNED DEDUCTIBLE, REQUIRED COPAYMENT, AND/OR PATIENT RESPONSIBILITY MUST BE COLLECTED BY OUR OFFICE AS PART OF OUR LEGAL CONTRACT WITH THAT INSURANCE COMPANY.

Patients who do not call the office to cancel within 24hrs of their appointment or do not arrive for a scheduled appointment may be charged for the visit in full.

If you have any questions, or need to request a payment plan, please contact us at 360-746-8827 to prevent late charges or collections activity.
Thank you for reviewing our office policies. By signing this document, you are agreeing to the information herein.
Sincerely,
Bellingham Osteopathic Center, PC

_____	_____	_____
Patient/Legal Guardian Signature	Patient/Legal Guardian Printed Name	Date

1712 D Street, Bellingham WA 98225
PH: 360-746-8827/ FX: 360-746-8882

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment and necessary information from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by these restrictions.

Patient Name _____

Relationship to Patient (if under 18) _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date: Initial: Reason: