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: (Please circle) 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, ____, college____, professional___, trade school____ , position at work _____

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: _____ Phone: _____

Address:_____

Reason for today's visit:

_____

_____

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

_____

_____

***Allergies to Medications:**

_____

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".

Signature: _____ Date:_____

Guardian Signature: _____ Date:_____

(If the patient is under 18)

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:_____
_____
_____

VACCINATIONS: Pneumonia vaccine date: _____ Influenza vaccine date:_____ Other: _____

FAMILY HISTORY: Please circle appropriate response and then describe conditions/illness of family members

Mother: Healthy (Yes) (No) condition/illness:_____
Deceased (Yes) (No) condition/illness:_____
Father: Healthy (Yes) (No) condition/illness:_____
Deceased (Yes) (No) condition/illness:_____
Siblings: Healthy (Yes) (No) condition/illness:_____
Deceased (Yes) (No) condition/illness:_____
Children: Healthy (Yes) (No) condition/illness:_____
Deceased (Yes) (No) condition/illness:_____

Please circle any of the following conditions present in all relatives: cancer, heart problems, asthma, COPD, allergies, headaches, diabetes, hypertension, kidney disease, gallbladder disease, weight issues, structural issues.

MEDICAL HISTORY: Please circle any of the following illnesses or conditions that you have had:

Systemic Illnesses: measles, chickenpox, whooping cough, croup, mumps, mononucleosis, scarlet fever, staph/strep infection, sepsis, meningitis, HIV, cancer (list type/stage_____)

Neurological System: headaches (please list age of onset___frequency_____location_____duration_____)
Migraine, epilepsy, weakness/burning/numbness in extremities, loss of consciousness, head injury, dizziness, vertigo

Mental Function: depression, anxiety, dementia, memory loss, Alzheimers, concentration difficulties, ADHD

Musculoskeletal System: scoliosis, back pain, neck pain, cramping/spasms in extremities, osteoarthritis, rheumatoid arthritis, gout, SLE (lupus), knee problems, shoulder problems, hip problems, ankle sprains

Dermatological System: dermatitis, psoriasis, eczema, melanoma, other skin cancers
Eyes: vision problems, glaucoma, macular degeneration

ENT: sinusitis, allergies, ear infection, tinnitus, thyroid disease
Cardiac: hypertension, 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, please list number and ages of children _____

Women: PMS, hot flashes, infertility, miscarriages, breast cancer, menstrual difficulties, pregnancies (list number and complications or terminations)_____

SURGICAL HISTORY:
Please list all surgeries with approximate date:
_____
_____
_____
_____
_____

TRAUMA HISTORY:
Please list all fractures, head injuries and other traumas, with dates of occurrence: _____
_____
_____
_____
_____

DIAGNOSTIC TESTING/IMAGING:
Please list all significant lab tests, x rays, CT scans, MRIs, etc.., approximate dates and results:
_____
_____
_____
_____
_____

Please list **all current physicians, practitioners and therapists**, and the reason for treatment:
_____
_____
_____
_____
_____

LIFESTYLE HISTORY: Please circle any that apply to you and answer blanks where appropriate
Dietary Habits: regular, vegetarian, vegan, diabetic, gluten free, dairy free, low fat, low calorie, high fiber, low fiber paleo/low carb, intermittent fasting
Exercise: type: flexibility, aerobic; intensity: low, medium, high; duration: ___minutes; frequency: _____/week
Smoking: never, previously, currently; amount per day _____
Alcohol use: never, occasionally, socially, daily; type _____; drinks per week_____
Caffeine use: coffee, tea, soda, energy drinks; amount per day_____
Drug use history: cannabis (CBD, THC), stimulants, psychoactive pharmaceuticals, street drugs
Vision: reading glasses, prescription glasses, prescription 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, dental appliances, approx. date of last cleaning _____
Household: relationship status: single, married, partnered, separated, divorced, widow/er, other; pets: yes, no
Exposure History: mold, lead, well water, radiation, toxic chemicals, toxic biological, other
Life Stressors: change in family dynamic, medical issues, financial hardship, job change or loss, loss of loved one, loss of relationship, new relationship, recent marriage, recent pregnancy, moving
Safety: fall in the last year, gait issues, strength issues, postural hypotension, home safety issues
Social: education level: eighth grade, high school, trade school, some college, bachelor's degree, master's degree, doctoral degree, professional degree; Veteran: yes, no, branch of military_____
Occupation: _____ Employment Status: full time, part time, retired, unemployed, self employed
Stress level: overwhelming, high, moderate, low; Reason for stress: financial, personal, relationships, work

PHQ9 Depression scale: please rate accordingly: O=none, 1=several days, 2=more than half, 3=every day
Having little interest of pleasure in doing things: ____
Feeling down, depressed or hopeless: ____
Trouble falling/staying asleep, or oversleeping: ____
Tired or low energy: ____
Appetite or overeating: ____
Feeling like a failure/let self or family down: ____
Difficulty concentrating: ____
Moving extremely slowly/or extremely restless: ____
Thoughts of self-harm or wishing to be dead: ____
How difficult have these problems made daily routine, work and relationships: ____

CURRENT COMPLAINTS/PAIN:
Is your current pain/complaints related to a specific accident or incident: Yes No: please describe: _____
_____
_____

Please describe location/symptoms/onset dates of each complaint:
_____
_____

Does your pain radiate or move to another part of your body? Yes or No; Where? _____
_____

What makes the pain/complaints better? _____
What makes the pain/complaints worse? _____
Did the pain/complaint start suddenly or slowly? Describe?
_____

How have the complaints/pain changed since they began?
_____

Did your pain/complaints start suddenly or slowly?
_____

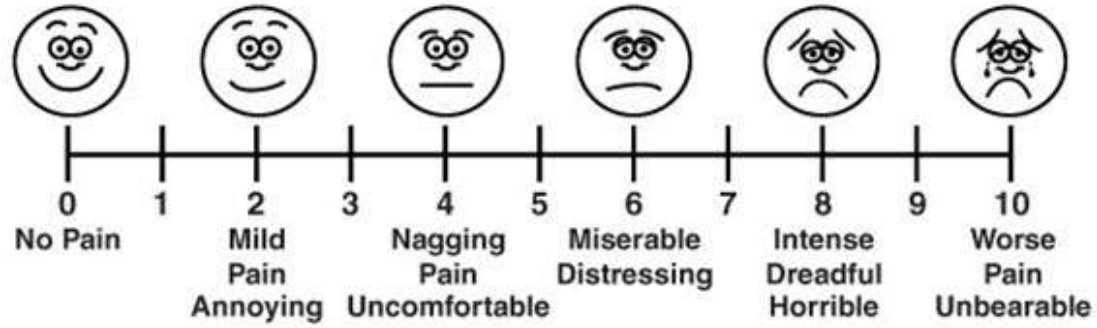
Have you had any numbness/tingling, swelling, weakness or paralysis in limbs or elsewhere? Where?
_____

Are your pains/complaint worse with certain movements? Explain:
_____

Are you pain/complaints present all the time, or do they come and go? _____
Have you had these pains/complaints before, or is this the first time? _____

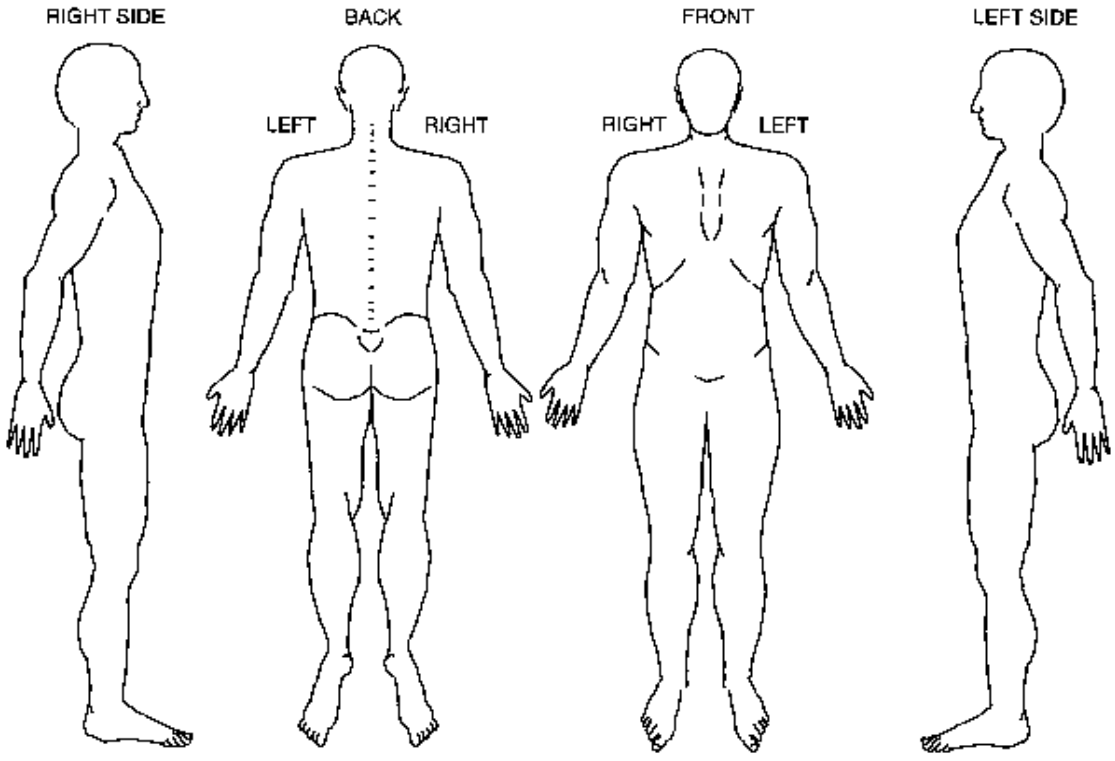
Are your pains/complaints present continuously, or intermittently? _____
Are your pains/complaints worse with certain movements or activities?
Describe:_____
_____
Have you pains/complaints changed since they started? _____
Please circle any of the following that apply to your complaints/pain: swelling, fever, weight change, rash, visual changes, chest, pain, nausea, vomiting
Do your pains/complaints affect any of the following: (please circle) 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? _____
What treatments have you tried for your pains/complaints? _____
_____

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	STANDING	OTHER
//////////	BBBBBBB	XXXXXXXX	- - - - - - - - - - - -	SSSSSSSSS	



BELLINGHAM OSTEOPATHIC CENTER, PC
Review of Systems

Name: _____ Date:_____

REVIEW OF SYSTEMS
(Please circle any that you have ever had)

CONSTITUTIONAL: chills, fever, weight loss, weight gain, decline in health, weakness, fatigue

HEAD: dizziness, headaches, fainting, pain, head injury, sweats

EYES: blurry vision, double vision, eyeglass use, pain with light, unusual sensation, cataracts, excessive tearing, glaucoma, recent injury, vision loss, discharge, eye pain, infections, redness

NOSE: discharge, infections, sinus infections, frequent colds, nasal obstruction, hay fever, nosebleeds

MOUTH: bleeding gums, postnasal drip, change in dentition, tongue burning, hoarseness, voice changes

EARS: discharge, hearing impairment, ringing in ears, dizziness, infections, hearing aids, pain

THROAT/NECK: frequent sore throat, tonsils enlarged, lumps, tenderness

RESPIRATORY: asthma, coughing blood, positive TB test, sputum, bronchitis, pain, recent chest X-ray, tuberculosis, cough, pleurisy, short of breath, wheezing

CARDIOVASCULAR: chest pain, hair loss on legs, high blood pressure, palpitations, short of breath with exertion, short of breath lying flat, short of breath sleeping, swelling of legs, varicose veins, extremity cool, heart murmur, history of heart attack, recent EKG, heart tests, leg pain walking, rheumatic fever, ulcers on legs, thrombophlebitis, extremities discolored

GASTROINTESTIONAL: abdominal pain, black tarry stools, change in stool color, decreased appetite, excessive thirst, hemorrhoids, jaundice, nausea, swallowing problem, abdominal Xray tests, change in frequency of bowel movement, change in stool consistency, diarrhea, gallbladder disease, hepatitis, laxative use, rectal bleeding, vomiting, antacid use, change in stool caliber, constipation, excessive hunger, heartburn, infections, liver disease, rectal pain, vomiting blood

MUSCULOSKELETAL: arthritis, gout, muscle cramps, restricted motion, back problems, joint pain, muscle stiffness, weakness, deformities, joint stiffness, paralysis

BELLINGHAM OSTEOPATHIC CENTER, PC
Review of Systems

PSYCHIATRIC: Behavioral change, disturbing thoughts, memory loss, psychiatric disorders, depression, excessive stress, mood changes, disorientation, hallucinations, nervousness
On a scale of scale of 0-9 what level of depression do you experience? _____

NEUROLOGICAL: Blackouts, fainting, loss of consciousness, paralysis, tingling, burning, head injury, memory loss, speech disorders, tremors, dizziness, headaches, numbness, strokes, unsteady gait

SKIN: Dryness, hair dye, itching, nail appearance change, skin color change, easy bruisability, hair texture change, lumps, nail texture change, eczema, hives, mole changes, rashes

BREASTS: Discharge, self-examination, lumps, tenderness, pain

ENDOCRINE: Cold intolerance, goiter, neck pain, weakness, excessive urination, heat intolerance, sweats, weight gain, fatigue, increased thirst, thyroid trouble, weight loss

HEMATOLOGIC/LYMPHATIC: Anemia, easy bruisability, swollen glands, bleeding easily, lumps, transfusion reaction, blood clots, radiation exposure

ALLERGIC/IMMUNOLOGIC: Coughing, itchy eyes, runny nose, watery eyes, coughing with exercise, itchy nose, sneezing, wheezing, hives, recurrent infections, stuffy nose, wheezing with exercise

URINARY: Awakening to urinate, burning, flank pain, infections, stones, urine odor, bed wetting, difficulty starting stream, frequency, pain on urination, urgency, blood in urine, excessive urination, incontinence, retention, urine discoloration

MALE: Discharge, impotence, prostate problems, venerial disease, sexual problems, fertility problems, lesions, scrotal masses, hernias, pain

FEMALE: Birth control, change in period flow, difficult pregnancy, hernias, menopause, postmenopausal bleeding, sexual problems, bleeding between periods, changes in period intervals, discharge, itching, menstrual pain, recent Pap smear, venerial disease, changes in period duration, DES exposure, fertility problems, lesions, pain with intercourse, recent pregnancy

BELLINGHAM OSTEOPATHIC CENTER, PC
Office Policies

Dear Patient,

Welcome! This contract will acquaint you with our office policies. Please review this information carefully and sign below. Thank you!

The physicians at Bellingham Osteopathic Center (BOC) are considered specialists, not primary care providers. This can affect copayment amounts and the need for a referral. We recommend that patients have a primary care physician for referrals to our office, and their primary care needs. Dr. Swan and Dr. Stanley treat all ages and all conditions within the context of their specialties. More information can be found at bellinghamdo.com.

Dr. Keith C. Swan, DO specializes in traditional Osteopathy and Medical Acupuncture.

Dr. Sharon Ann Stanley, DO specializes in traditional Osteopathy and Classical Homeopathy.

INSURANCE:

Bellingham Osteopathic Center is contracted with most insurance plans. If you do not see your insurance plan listed below, we will be happy to assist you with specific coverage or plan questions. All questions regarding the 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. **It is also the patient's responsibility to get a specialty referral if required by their insurance plan.**

Any amount not covered by insurance, for whatever reason, may be owed by the patient to Bellingham Osteopathic Center. It can require up to ten weeks for final billing clarifications.

We are currently contracted with: Medicare Plans, Kaiser (PPO), Regence, Premara, Blue Cross/ Blue Shield, Multiplan/Beechstreet/ PHCS, Tricare, Cigna, Humana, Aetna, Lifewise, First Choice, Uniform and United Heathcare (UHC) (no Community Plan).

We are unable to accept the following at this time: Workman's Compensation, Medicaid (Apple, Melina), Disability Insurance and Personal Injury Liens.

If you have Medicaid (DSHS/Provider One) secondary to Medicare, you will be responsible for all Medicare deductibles and coinsurance amounts for any plans other than QMB (Qualified Medicare Beneficiaries) Dr. Stanley and Dr. Swan do not participate in depositions, court testimony on a patient's behalf or as expert witnesses unless previous arrangements have been made with the attorney.

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.

If you have any questions regarding credit card payments, check payment or clearance, or need a payment plan arranged, please contact us at 360-746-8827 to prevent late charges.

Insurance companies will send you an EOB (Explanation of Benefits) which describes coverage amounts, copayment and coinsurance information, as well as specific adjustments and deductible applications. Any deductible will be credited toward your annual insurance deductible, and will then be owed to Bellingham Osteopathic Center at the next billing cycle.

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

PLEASE CONTACT YOUR HEALTH INSURANCE CARRIER FOR SPECIFIC QUESTIONS REGARDING YOUR SPECIFIC PLAN, COVERAGE, REFERRAL REQUIREMENTS AND EXPLANATION OF BENEFITS.

Thank you for reviewing our office policies. By signing this document, you are agreeing to the information herein.

Sincerely,

Bellingham Osteopathic Center, PC

_____ _____ _____

Patient Signature (Or Legal Guardian signature for minors) | Patient Printed Name (Or 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: