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: _____Occupation: _____Employer_____

Emergency Contact Name: _____Relationship: _____Phone: _____

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 #: _____

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)