2bwell, Inc

5935 Willow Lane, Lake Oswego – OR 97035
Phone: (503) 655-0044 / Fax: (503) 515-8099 / URL: www.2bwell.net

REGISTRATION FORM

Today's date:	SSN (strictly confidential):

PATIENT INFORMATION

Last name: First: Middle:	What should we call you?	Marital status (circle one) Single / Mar / Div / Sep / Wid

OK to leave messages for you from the clinic? ❑ Yes ❑ No	Weight: *Now* - *One year ago*	Height:	Birth date: / /	Age:	Biological Sex: Gender:

Street address:	Home Phone: ( ) -
	Work Phone: ( ) -

City:	State:	ZIP Code:	Cellular Phone: ( ) -

Employer:	Occupation:	E-Mail Address:

Chose 2bwell because/Referred to us by (please check one box):	❑ Dr.	❑ Insurance Plan:	❑ Direct Mail

❑ Yellow Pages	❑ Close to home/work	❑ Friend:	❑ Family:	❑ Other:

INSURANCE INFORMATION

(Please provide your insurance card to our receptionist before filling this part)

Insurance company:	Policy #:	Address:	Phone #: ( )

Insured name:	Insured S.S. #:	Birth date: / /	Group no:	Co-payment:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

As a service to our patients, 2BWell, Inc will finance the account and carry the balance while submitting the charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office.

We may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever amounts the insurance does not pay.

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize 2bwell, Inc or insurance company to release any information required to process my claims.

I agree to be responsible for payment of services in the event my insurance company doesn't agree to pay for these services. Not signing this document does not release you from responsibility of payment.

Patient/Guardian signature **Date**

HEALTH HISTORY QUESTIONNAIRE

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

PLEASE LIST PREVIOUSLY DIAGNOSED MEDICAL PROBLEMS:

1.	Dr's Name:	When:
2.	Dr's Name:	When:
3.	Dr's Name:	When:

Please list your current medical complaints:

1.

2.

Allergies to Medications:	
Other Known Allergies:	
Previous Injuries: (dislocations, sprains..)	

PLEASE LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER SUPPLEMENTS.

Name	Strength	Frequency Taken

Lifestyle

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (at least 4x/week for 30 minutes)				
Diet	Are you on any diets at this time?			☐ Yes	☐ No
	If yes, is it a physician prescribed medical diet?			☐ Yes	☐ No
	Name of the diet and # of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	# of cups per day:
Alcohol	☐ None	☐ 1-3 drinks/month	☐ 4-8 drinks/month	☐ 3-7 drinks/week	☐ more
Tobacco (if using)	☐ Cigarettes – pks./day	☐ Cigars - #/day	☐ Pipe - #/day	☐ Chew - #/day	
	☐ # of years	☐ Or years since quit			
Public safety	Do you have any contagious, or sexually / bodily fluids, transmitted disease?			☐ Yes	☐ No
	Have you ever used IV street drugs?			☐ Yes	☐ No
Personal	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH		AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH
FATHER			***Children***	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

Female at Birth

Age at onset of menstruation:	Date of last menstruation:	Cycles are every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your cycles?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Male at Birth

Do you usually get up to urinate during the night? If yes how many times?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate exam?	☐ Yes	☐ No

Consent Form

All the therapeutic services performed by practitioners at 2bwell Clinic are aimed to prevent and treat pain, disease, or other dysfunctions. Adverse side effects may result. These include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to receiving treatments. Practitioners at 2bwell Clinic may recommend and perform Acupuncture and Oriental Medicine, Naturopathic Medicine, Massage Therapy, and utilize nutritional supplements as means of prevention or treatment modalities. Adverse side effects may result from taking nutritional supplements. These include, but are not limited to, changes in bowel habits, temporary abdominal pain or discomfort, and the possible temporary aggravation of existing symptoms. If I experience any problems to which I associate with these supplements, I understand that I should stop taking them and contact my practitioner.

The above treatment modality and related risks have been explained to me by my practitioner, and I had the opportunity to ask questions. I hereby consent to:

__ ***Acupuncture and Oriental Medicine treatments.***
__ ***Naturopathic Medicine treatments.***
__ ***Massage Therapy***

Signature of Patient, Parent or Guardian **Date**

Systems Review

For the following, please circle:
Y=a condition you now have **P**=a condition you had before **N**=a condition you never had

Headaches	Y P N	Difficulty breathing	Y P N	Diabetes	Y P N
Migraines	Y P N	Palpitation/Fluttering	Y P N	Seizure	Y P N
Spots in eyes	Y P N	Swelling in ankles	Y P N	Rashes	Y P N
Blurring	Y P N	Fainting	Y P N	Itching	Y P N
Ringing in ears	Y P N	Heart Disease	Y P N	Glaucoma	Y P N
Numbness /tingling	Y P N	Heartburn	Y P N	Nausea/Vomiting	Y P N
Jaw/TMJ problems	Y P N	Constipation	Y P N	Diarrhea	Y P N
Glasses or contacts	Y P N	Blood in stool	Y P N	Gall bladder disease	Y P N
Tearing or dryness	Y P N	Pain on urination	Y P N	Kidney stones	Y P N
Impaired hearing	Y P N	Frequency at night	Y P N	Joint pain or stiffness	Y P N
Cough	Y P N	Frequent infections	Y P N	Weakness	Y P N
Asthma	Y P N	Sleep soundly	Y P N	Fatigue	Y P N
Shortness of Breath	Y P N	Trouble falling asleep	Y P N	Depression	Y P N
Chest pain	Y P N	Dream excessively	Y P N	Easily stressed	Y P N
Bronchitis	Y P N	Arthritis	Y P N	Anxiety/nervousness	Y P N

Effective Date: February 25, 2003

Notice of Patient Privacy Health Insurance Portability and Accountability Act (HIPPA)

2BWell Clinic is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. Required by law: We must have your written consent before we use or disclose to others your Medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact 2BWell Clinic via email; office@2bwell.net or phone; (503) 655-0044. You may also send a written complaint to the US Department of Health and Human Services.

_____ _____
Patient Signature Date

_____
Please Print Name