

NEW PATIENT REGISTRATION FORM

Please print the following information

PERSONAL INFORMATION

Date Today:

Name Birth Date Sex

First

M.I.

Last

Address City State Zip Country

Street Address

P.O. Box/Apt#

City

State

Zip

Country

Marital Status Race Education Email

Phone: (Home) (Work) (Cell)

Closest Relative

(include address)

Relative Phone: Spouse/Sig. Other Referred by

Employer Occupation

Medications, Herbs,

Home Remedies, etc.

Allergies (including medication)

Diet (please describe)- Breakfast

Lunch

Dinner

Exercise (please describe)

INSURANCE INFORMATION: Please fill out the following information for the holder of the insurance policy or legal gaurdian

Insurance Co. Group # Policy #

Insured Name Birth Date Sex

First

M.I.

Last

HOSPITALIZATIONS: YEAR OPERATION/ILLNESS NAME OF HOSPITAL CITY AND STATE

First

Second

Third

Fourth

CHIEF COMPLAINT

Reason for this visit

Was there an initiating event or was anything different within 6-12 months before the onset of the problem?

.....

.....

MEDICAL HISTORY

CHECK every condition that you have ever had.

CIRCLE conditions currently present.

WRITE the age of onset. 7 y/o

EYES

- Failing vision
- Double or blurred vision
- Squinting/"crossed" eyes/
- Asymmetric gaze
- Eye pain
- Eye infections
- Lose place when reading
- Poor reading comprehension
- Eyestrain or fatigue from reading
- Headache from reading
- Glasses or contacts
- Monovision/Progressive lenses

ENT

- Decreased hearing
- Loud voice
- Snoring/Mouth breathing
- Ringing/Buzzing in ears
- Ear infections
- Allergies/Hay fever/Runny nose
- Sinus problems
- Nose bleeds
- Frequent sore throats
- Prolonged hoarseness
- Speech problems

CARD-PULM

- Asthma
- Emphysema
- Chronic cough
- Bronchitis
- Pneumonia
- Tuberculosis
- Shortness of breath on exertion
- Shortness of breath on lying flat
- Chest pains
- Heart murmurs
- Palpitations
- Swollen ankles
- Fainting spells
- Leg pain when walking
- Varicose veins/Phlebitis

GI

- Eating disorder
- Recent loss of appetite
- Difficulty swallowing
- Heartburn
- Persistent nausea/vomiting
- Ulcers
- Chronic abdominal pain
- Recent change in bowel habits
- Diarrhea
- Constipation
- Black or tarry stools

- Red blood in stools
- Hemorrhoids
- Diverticulosis
- Gall bladder trouble
- Jaundice/Hepatitis
- Hernia

ENDO

- Chronic fatigue
- Recent weight loss
- Excessive weight gain
- Thyroid disease
- Cancer
- Diabetes

NEURO

- Convulsions/Seizure
- Stroke
- Tremors
- Muscle weakness
- Numbness/Tingling sensation
- Frequent headaches
- Clumsiness

MS

- Joint pain
- Scoliosis/Kyphosis
- Arthritis
- Gout
- Cold or numb feet
- Involved in contact sports

DERM

- Rashes
- Psoriasis
- Eczema
- Hives
- Unusual moles

PSYCH/EMOTIONAL

- Difficulty Sleeping
- Nightmares
- Nervousness/Anxiety
- Stress
- Depression
- Memory loss
- Moodiness
- Phobias
- Nail biting/thumb sucking
- Bad temper/breath holding/
- Jealousy

ILLNESSES

- Mumps
- Measles
- German measles
- Chicken pox
- Polio
- Scarlet fever

- Rheumatic fever
- TB

- Meningitis

HABITS

- Alcoholism
- Alcohol.....
- Cigarettepacks/day
- Coffee/Teacups/day

HEME

- Anemia
- Malaria
- Bruise easily/Bleeding
- Mononucleosis
- Unexplained lumps
- Fever/Chills/Excessive sweating

GU

- Bed wetting
- Bladder infections
- Kidney infection
- Pain on urination
- Poor control of urination
- Decreased force of urination
- Blood in urine
- Kidney stones
- Discharge from penis or vagina
- Sexually transmitted disease

FEMALE ONLY:

- Number of pregnancies
- Number of live births.....
- Number of miscarriages
- Method of birth control.....
- Age of onset of menses.....
- Flow: Light Moderate Heavy
- Period Not Regular
- Length of Flow
- Length of Cycle.....
- Pain/bleeding with intercourse
- PMS (medium to severe)

STRESS

- Check any of the following that occurred in your family the past year:
- Marriage Births Serious illness
 - Divorce Deaths Separation
 - Job loss Move Other.....

DENTAL

- Orthodontic treatment
- Dental extractions
- Crowns
- Root canal work
- Fillings
- Bridgework
- Retainer/Night guard
- Gum problems

Grind teeth

TRAUMA

List all following with age of occurrence

Falls

Bumps

Sprains/Strains

Concussions

Broken bones

Accidents

OTHER

PEDIATRIC Pediatric section for patients under 18 years old only.

PREGNANCY (Mother)

Mothers age when pregnant.....

What number pregnancy was this?

Number of abortions/Miscarriages?.....

Number of live births?.....

Unplanned pregnancy

Complications

In vitro

Artificial Insemination

Amniocentesis

Number of ultrasounds

Medications during pregnancy:

Trauma during the pregnancy

Illnesses during pregnancy

LABOR

False labor

How long was active labor.....

Difficult labor

Pitocin

Pain medication

Epidural or spinal anesthesia

DELIVERY

When was the baby born relative to the due date?.....

Baby's position

C-section

Forceps

Episiotomy

Vacuum extraction

Cord wrapped around the neck

Difficult/traumatic delivery

Meconium staining

NEWBORN

What was the birth weight

APGARs: 1 min.....5 min.....

Head asymmetrical/uneven at birth

Unusual cry at birth

NUTRITION

Breast

Formula.....

Other

Did NOT nurse immediately after birth

Difficulty nursing

INFANT

Spitting up

Rigidly arches backwards

Muscle tone feel loose or floppy

Muscle tone feel too tight or rigid

Torticollis (head and neck side-bent)

Colic

Age of first illness

Helmet use for uneven head

BABY

Age first sleep through night.....

Used a walker or any similar device

Used a swing

Growth and development problems

What age did your child:

Sit up Creep

Crawl Cruise

Walk..... Talk

SENSITIVITIES

Easily startled?

Food sensitivities

Picky eater

Difficulty wearing certain clothing

MOTOR SKILLS

Clumsiness

Difficulty drawing a straight line, circle, square, complex figure (age appropriate)

SCHOOL

Poor grades in school?

Homework difficult

Poor concentration/short attention span

Doesn't get along with classmates

EXPOSURE/HABITS

Possible lead exposure (old home/plumbing/peeling paint)

Smokers in household

TV – hours per day

Computers – hours per day

Video games – hours per day

Suck finger/thumb/lip/pacifier

Nail biting

Your relationship to child

Location of birth

Is the child yours by:

Birth Adoption Marriage

Other.....

Are both biological parents raising the child Yes No

Parents: Unmarried Married

Separated Divorced

Who lives in the home?

Father's professions

Mother's professions

Is your child:

Irritable Aggressive Shy

SIBLINGS

List all siblings

OTHER MEDICAL TREATMENT: List all Physicians from whom you are currently receiving treatment along with the condition(s).

PHYSICAN NAME

ILLNESS(ES)

TREATMENT PROGRAM

FAMILY HISTORY Please look down the list of diseases and check any listed family member that applies.

Medical Condition \ Relative	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Problem												
Cancer												
Congenital Anomaly/Birth defect												
Heart Disease												
Depression												
Diabetes												
Eczema												
Psoriasis												
Food allergy												
Genetic disorder												
Hay Fever												
Hearing disorder												
Kidney disease												
High Cholesterol												
High blood pressure												
Immune disorder												
Mental retardation/Learning disorder												
Scoliosis/Kyphosis												
Stroke												
Substance abuse												
Thyroid disorder												
Tobacco use												
Tuberculosis												
Death before age 56												
Other												
Other												

IMMUNIZATIONS Please list any type of immunization reaction or adverse effect.

Immunization	Describe reaction including severity, length of time, and age.
DPT	
Tetanus booster	
Polio	
MMR	
Hib	
Varicella	
Pprevnar	
Hepatitis A	
Hepatitis B	
Other	

Office Policy And Informed Consent For Treatment With Osteopathic Manual Medicine

Thank you for selecting our office for evaluation and osteopathic treatment. We look forward to serving you.

D.O.s AND OSTEOPATHIC MANUAL MEDICINE

An osteopathic physician is a fully licensed physician (i.e. licensed to prescribe medication and perform surgery) whose education combines the traditional methods of diagnosis and treatment as well as osteopathic manual medicine (manipulation).

Osteopathic manual medicine is a form of treatment based on the concept that the structure of the human body influences the function. The goal of treatment is to improve the body's structure that in turn enables the body to function at a higher level of health. This usually reduces the amount of pain experienced by the patient as well as increases the ability of the body to fight disease (i.e. stimulate the immune system). As in most forms of medical treatment, no specific results can be guaranteed.

TREATMENT PROGRAM

The physician will ask questions, perform a physical examination, which includes the musculoskeletal system in order to detect any somatic dysfunction (abnormalities such as tenderness, asymmetry, restricted range of motion and abnormal changes in the muscles, joints, bones, connective tissue, etc.). The physician's goal is to locate then reduce or resolve this somatic dysfunction. Techniques range from a very light touch to more increased pressure.

Other recommendations may be given to help the dysfunction, such as diet, exercise, or stretching regimens.

TREATMENT RISKS

Patients rarely experience side effects as osteopathic manual medicine is considered one of the safest and most non-invasive forms of medical treatment. Most side effects occur from chiropractic or other forceful types of manipulation. Chiropractic manipulation is not utilized, nor is any form of treatment using quick forceful movement generated by the physician.

However, for purposes of disclosure, the following side effects have been reported from all forms of manual medicine:

- Worse pain after treatment, numbness or weakness, fractures (broken bones), spread of pre-existing conditions such as undetected cancer, breaking loose of blood clots, stroke and tears in blood vessels.

Although the above-listed complications are rare, patients should be made aware of the complications and some may be serious. Utilizing gentle techniques further reduces the occurrence of these rare complications.

In more common cases, patients may experience mild muscle soreness, fatigue, or tenderness, similar to excessive sports activities or flu-like symptoms. This vital reaction to treatment usually resolves within a few days.

APPOINTMENT

Your appointment is time set aside for you and your physician. Without a 24-hour notice, patients who forget their appointments or cancel at the last minute will be charged. Please understand we allow a significant amount of time for each patient visit and a missed appointment is lost time, which could have gone to a patient on the waiting list. Our office will endeavor to contact patients two working days in advance to confirm your appointment, however, the appointment is the patient's responsibility.

Initial evaluation and treatment lasts approximately 60-90 minutes. Follow-up treatments usually last 30-45 minutes.

POSITIVE ACCOUNT BALANCES AND RETURNED BANK ITEMS

To cover administrative costs, a late charge of a minimum of \$10 or 1.5% (whichever is greater) will be added to all accounts not paid in full each month. If your check is returned from the bank, we will add a "returned check" fee to your account, usually in the amount of \$25.

PAYMENT

Your insurance company may not reimburse for part or all of the physician's services. Please note that payment is required at the time of visit and that you or your legal guardian are personally responsible for any unpaid balance.

We will provide you with a "Superbill" (a form detailing medical treatment, diagnoses, and charges) for each visit, which can be submitted to your insurance company. We regret that we are unable to accept the following:

- Disability insurance
- Worker's Compensation
- MediCal
- Medicare
- Liens
- Assignment from an insurance carrier

Thank you for taking the time to read this agreement. We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery.

If you have any concerns or specific questions regarding the risks or benefits of treatment, please ask the physician before signing the consent form.

CONSENT FOR TREATMENT

I understand and agree to the above and agree to be treated. If the patient is a minor, I give my consent to have them treated.

Signature of patient or legal guardian

Date

Signature of witness

Date

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 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 such restrictions.

Patient Name _____

Relationship to Patient _____

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:

Initials:

Reason:

FOR THE BEST TREATMENT POSSIBLE

1. Sit back, relax and enjoy the treatment. The best time for questions is at the beginning of the visit. This enables the doctor to concentrate during treatment.
2. Treatment continues even after your appointment. Do not engage in strenuous activity for at least 24 hours following a visit.
3. Wear lightweight clothing: the doctor needs to palpate (feel) through the fabric to treat underlying abnormalities that are triggering your symptoms. Avoid jeans and other heavyweight material. Patients are asked to wear a gown during the initial exam but not for follow-up treatment.
4. Check with your doctor before incorporating other types of physical medicine (i.e. acupuncture, chiropractic, physical therapy, massage) into your treatment plan. A healing process is in motion. Please allow it to continue to work without interference.
5. Notify the doctor of impending dental work (i.e. expanders, braces, appliances, splints, crowns) as it often impacts the body's mechanics. Be advised that some dental treatment can worsen the condition the patient is trying to resolve. Some forms of dental treatment are more biomechanically favorable than others.
6. Be sure to let your doctor know if you wear glasses or use contact lenses. Your prescription could be contributing to strains in your body.
7. Treatments are designed to make powerful changes in your body. Occasionally patients experience vital reactions ranging from light-headedness to achy sensations, slight aggravation of symptoms. This is more common after the first or second treatment and seldom occurs after that. Symptoms typically resolve within 24 to 48 hours. Drink plenty of water (room temperature) to flush your system.
8. Arrive on time. You do not want to cut your appointment short by being late. Take advantage of every minute to improve your health.
9. Note to parents: Although one adult caretaker is welcome in the room at any time, it is sometimes easier to treat children with just a staff member assisting the doctor. Other children in the room usually distract the physician and the patient, decreasing the treatment's effectiveness.