

PATIENT REGISTRATION FORM

Please print the following information

PERSONAL INFORMATION

Date

Name Birth Date Sex

First M.I. Last

Address City State Zip Country

Street Address P.O. Box/Apt#

Phone: (Day) (Eve.) SS#

Area Code Number Area Code Number

D.L.# Marital Status Race Education

Closest Relative (include address)

Relative Phone: Spouse/Sig. Other Referred by

Employer Occupation

Medications you are currently taking

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 guardian

Insurance Co. Group # Policy #

Insured Name Birth Date Sex

First M.I. Last

Insured Address City State Zip Country

Street Address P.O. Box/Apt#

Phone: (Day) (Eve.) SS#

Area Code Number Area Code Number

FAMILY HISTORY: If any blood relative has suffered any of the following, please indicate which relative.

Allergies Asthma Anemia Arthritis Cancer

Alcoholism Diabetes Epilepsy Glaucoma Genetic Disease

Gout Headaches Stroke Ulcers Tuberculosis

Kidney/Bladder Problem Mental Illness Heart Disease

Blood Clotting Problems High Blood Pressure Other

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

First

Second

Third

MEDICAL HISTORY

CHECK every condition that YOU HAVE EVER HAD.

No Longer Present

CIRCLE those conditions that ARE STILL ACTIVE.

Currently Present

NEXT TO any checked item write the AGE OF ONSET.

Age Began 7 y/o

EENT

- Failing Vision
- Double or blurred vision
- Eye Pain
- Eye Infections
- Decreased hearing
- Ringing/Buzzing in ears
- Ear Infections
- Allergies/Hay Fever
- Sinus Trouble
- Nose Bleeds
- Frequent Sore Throats
- Prolonged Hoarseness

- 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

MS

- Arthritis
- Gout
- Cold or Numb Feet

DERM

- Rashes
- Psoriasis
- Eczema
- Hives

OTHER

- Difficulty Sleeping
- Nervousness
- Anxiety
- Depression
- Memory Loss
- Moodiness
- Phobias
- Mumps
- Measles
- German Measles

- Chicken Pox
- Polio
- Scarlet Fever
- Rheumatic Fever
- Alcoholism
- Alcohol:
- Cigarette packs/day
- Coffee/Tea cups/day

HEME

- Anemia
- Malaria
- Bruise Easily
- Mononucleosis

GU

- Bladder Infections
- Kidney infection
- Pain on Urination
- Poor control of Urination
- Decreased force of Urination
- Blood in urine
- Kidney Stones
- Sexually Transmitted Disease

FEMALE ONLY:

- Number of Pregnancies.....
- Number of Live Births.....
- Number of Miscarriages.....
- Method of Birth Control.....
- Age of onset of menses.....
- Period Not Regular
- Light Flow
- Moderate Flow
- Heavy Flow
- Length of Flow.....
- Length of Cycle.....
- Pain/bleeding with intercourse
- PMS (medium to severe)
- Other.....
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OTHER MEDICAL TREATMENT: Please list all other physicians whom you are currently receiving treatment from and list the condition(s) for which you are being treated.

PHYSICAN NAME

ILLNESS(ES)

TREATMENT PROGRAM

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OFFICE POLICY

Dear Patient,

Welcome. To help you get acquainted with the office, we have prepared a few words about our policies and fee schedules. Please read this and sign below indicating that you understand the guidelines.

YOUR APPOINTMENT

Your appointment is time set aside for you and your physician. 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. So, without a 24-hour notice, patients who forget their appointments or cancel at the last minute will be charged. Our office will endeavor to contact patients 48 hours in advance to confirm your appointment.

CURRENT FEE SCHEDULE:

- Initial evaluation and treatment approximately 60-90 minutes
- Follow-up treatments approximately 30-45 minutes
- Payment is required at the time of visit.
- We will provide the patient with a “Superbill” (a form detailing medical treatment, diagnoses, and charges for submission to your insurance carrier) for each visit; however, we regret that we are unable to accept the following:
 - (1) Disability Insurance
 - (2) Worker’s Compensation
 - (3) MediCal
 - (4) Medicare
 - (5) Liens
 - (6) Assignment from your Insurance Carrier

POSITIVE ACCOUNT BALANCES AND RETURNED BANK ITEMS

To cover our administrative costs, we will add a late charge of a minimum of \$15 up to a maximum of 1.5% on all accounts not paid in full each month. If your check is returned from the bank, we will add the “returned check” fee to your account, usually in the amount of \$25.

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

Patient signature

Date

FOR THE BEST TREATMENT POSSIBLE

- 1) Please be on time. If a patient is late by 10 or 20 minutes, this compromises the physician's schedule and has a domino effect on the remaining scheduled patients. Your doctor endeavors to be on time; however, your treatment may end after the scheduled time.
- 2) Allow the treatment to go on working. Do not engage in any strenuous physical activity until the day after treatment.
- 3) Consult your Osteopathic Physician before incorporating other types of physical medicine as this can interfere with your treatment. This includes physical therapy, chiropractic, acupuncture, orthotics, orthodontics (bite plates, night guards, braces), bite adjustments, and any type of manual therapy or biomechanical device.
- 4) Do not wear jeans or other clothes of heavyweight material during time of treatment. Heavyweight fabric is difficult for the physician to treat through. Patients are required to partially undress for the initial examination but not for follow-up treatment.
- 5) After the initial treatment, patients may experience a "vital reaction" meaning you may feel slight aching sensations the day after your first treatment. The physician has made several changes in your body to stimulate the immune system. Drink plenty of water (not iced) to help flush your system. This reaction generally resolves itself within 48 hours after treatment.
- 6) Allow your physician to concentrate during treatment. Please turn off all beepers and cell phones and ask your questions at the beginning of your visit. The remaining time will be spent on your treatment. Also, conversation can distract the physician as well as bringing an additional family member in the treatment room. Your doctor wants to ensure that you receive the best treatment possible.
- 7) Relax and enjoy the treatment.

Please Note: For more active or behaviorally challenged children, the physician may ask that the office manager be present during treatment in lieu of a parent. Children are usually much easier to treat when the parent is not present.

Please consult with your D.O. before starting *any* orthodontic treatment regime as this can profoundly affect body structure and function.