PERSONAL and FINANCIAL INFORMATION

Patient Name: _____

Date of Birth:_____ Preferred Pronoun:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Parent/guardian if patient is a minor: _____

Name of Employer: _____ Name of referring Physician: _____

Is this: an ***on the job injury (WC)***? _____ a ***motor vehicle accident injury (MVA)*** ? _____

If yes; What is your injury/accident date? _____

WC or MVA claims: If you have an attorney, please provide their name, address and phone #:

_____

_____

Please check here if you do not have insurance _____

If you have insurance, please give your card to the receptionist to copy and fill out the following:

Insurance Company Name: _____

Address: _____

Claim # (WC/MVA) _____ ID# _____Group# _____

Subscriber: _____ Relationship to patient: _____

Subscribers' date of birth: _____

Who is your primary care physician? _____

****

Patient statement of understanding: Co-payments are due at the time of service, as are uncovered services, unless prior arrangements have been made with the business office. I authorize the release of information in my medical records to the insurance company billed if they request it, to process my claim. I also assign my insurance benefits as payable to my health care provider. I understand that my insurance will be billed as a courtesy, and I assume responsibility to resolve any benefit disputes with my carrier. I also assume responsibility for costs incurred beyond what is covered by my medical insurance.

Patient/Guardian Signature: _____ **Date:** _____

Personal and Medical History

Name: _____ Age: _____ Birth Date: _____/_____/_____

Height: _____ Weight: _____ Dominant hand: _____ Primary doctor: _____

Who referred you to this clinic? _____

Circle Past/Present Illnesses: Addiction, Asthma, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Liver Disease, Lung Disease, Rheumatic Fever, Seizure Disorder, Stroke, Tuberculosis, Ulcers,

Other _____

Past Surgeries: _____

_____

Past Significant Injuries: _____

_____

Prescription Medications: (or provide a separate list)

Name						
Dose						
Number per day						
For how long?						

Non-Prescription Medications: (or provide a separate list) _____

_____

Medication allergies: _____

Circle Family Illnesses: Addiction, Asthma, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Liver Disease, Lung Disease, Rheumatic Fever, Seizure Disorder, Stroke, Tuberculosis, Ulcers,

Other _____

How much of these substances do you use per day?

Caffeine	Alcohol	Tobacco
-Coffee: _____ cups	- Beer: _____ cans / bottles	- Cigarettes: _____ packs
-Tea: _____ cups	- Wine: _____ glasses	- Chew: _____cans
-Other: _____	- Other: _____	- Other: _____

Please describe your exercise habits: _____

_____

Please describe any special dietary restrictions: _____

Occupation: _____ Part time / Full time

Review of Systems: Check any of the following symptoms you have *recently* experienced:

Constitutional
__ weight loss
__ fatigue
__ chills
__ fevers
__ night sweats
__ insomnia

Eyes
__ double vision
__ change in vision
__ blurred vision
__ eye pain
__ eye discharge
__ dry eyes
__ eye redness

Ears
__ plugged ears
__ hearing loss
__ noise in ears
__ ear pain
__ impacted wax
__ hearing aids

Nose
__ runny nose
__ stuffy nose
__ nosebleeds
__ ulcers or sores
__ sinus pain
__ sneezing

Throat
__ tooth pain
__ bleeding gums
__ hoarseness
__ grinding or clenching jaw
__ sore throat
__ jaw pain

Respiratory
__ chronic cough
__ cough with exercise
__ coughing blood
__ wheezing
__ short of breath
__ snoring / apnea

Cardiovascular
__ high blood pressure
__ heart races or skips
__ chest pain
__ leg swelling
__ leg pain with walking
__ varicose veins
__ short of breath with exercise

Gastrointestinal
__ trouble swallowing
__ heartburn
__ black stool
__ blood in stool
__ poor appetite
__ nausea
__ vomiting
__ diarrhea
__ constipation
__ hemorrhoids
__ abdominal pain

Genitourinary
__ burning with urination
__ frequent urination
__ change in urine stream
__ urinary infection
__ blood in urine
__ kidney stones
__ urine leakage

Musculoskeletal
__ joint pain
__ muscle aches
__ morning stiffness
__ back pain
__ joint swelling
__ weakness
__ short leg/wear a shoe lift
__ scoliosis
__ spondylolisthesis
__ spasms/cramps
__ bone pain

Neurological
__ migraine
__ headache
__ seizures
__ numbness/tingling
__ radiating pain to legs or arms
__ slurred speech
__ memory loss
__ tremors
__ dizziness/vertigo
__ fainting
__ loss of balance
__ stroke
__ gait problem
__ paralysis

Mental health
__ anxiety
__ depression
__ memory change
__ panic attacks
__ alcohol or drug dependence

Skin
__ rashes
__ hives
__ skin change

Allergic/Immune
__ allergic reactions
__ hay fever
__ frequent infections
__ hepatitis
__ autoimmune disease

Hematologic
__ easy bruising
__ prolonged bleeding
__ blood clots

Endocrine
__ heat/cold intolerance
__ excessive sweating
__ excessive thirst or urination
__ osteoporosis

Female specific symptoms
__ breast pain
__ breast lumps
__ nipple discharge
__ hot flashes
__ menopause
__ change in menstrual cycle
__ postmenopausal bleeding
__ pain with intercourse

In order for Dr. Brian Moreaux to get to know more about the issue(s) bringing you to the clinic, would you please take a moment to fill out this form? Thank you for your time.

What symptoms do you have that led you to seek help from Dr. Moreaux?

When did your symptoms start? Was there an accident or injury?

Where is your pain? Where does it spread to?
(Please feel free to use the drawing on the other side of this form if you prefer to illustrate your symptoms)

Circle what makes your pain worse:
Sitting / Standing / Bending / Twisting / Lifting / Pushing / Pulling / Coughing / Sneezing / Walking / Sexual activity / Heat / Cold / Riding in a car / Other: _____

_____

Circle what makes your pain better:
Sitting / Standing / Changing positions / Walking / Lying down / Relaxing / Stretching / Exercising / Heat / Cold / Medicine / Massage / Other: _____

_____

What medications or other therapies have you used to relieve this pain?

Have you had any muscle weakness of your arms, hands, legs or feet since this pain began?

Have you had any loss of feeling or numbness?

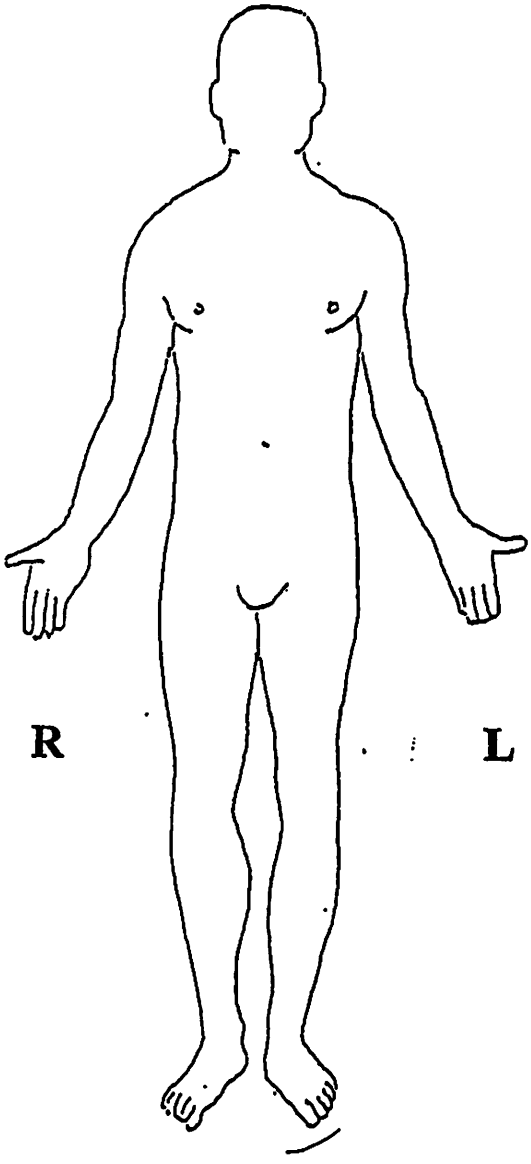
Have you had any problem controlling your bladder or bowels since this pain started?

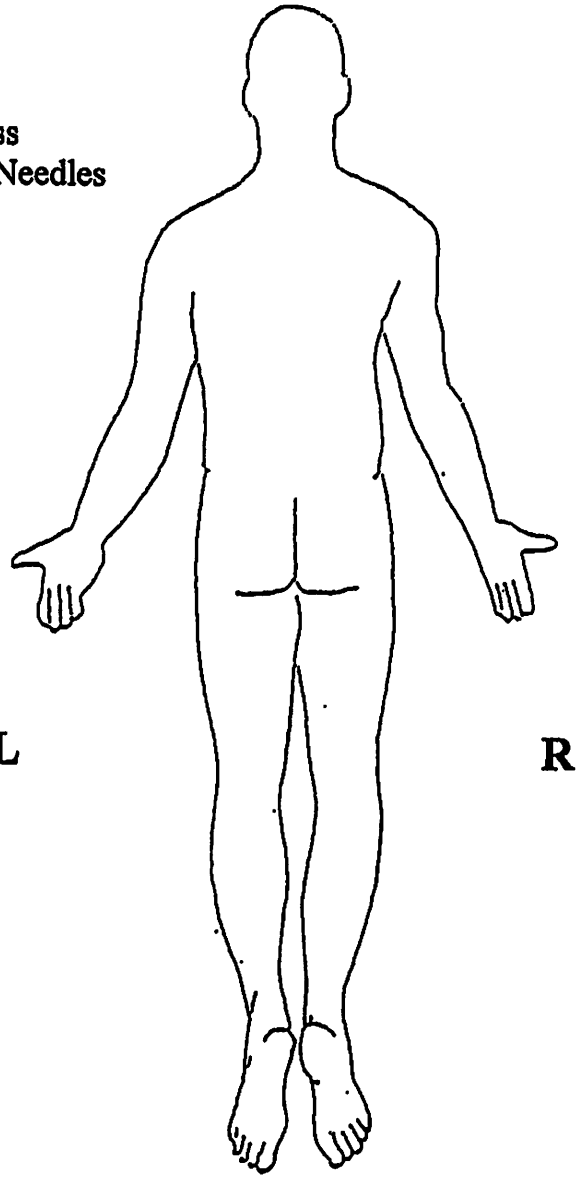
Have you missed any work time due to this pain? If so, please give specific dates.

REVIEW OF SYMPTOMS

The information on this form will be very useful to the doctor you will be seeing today, and will help your exam go as smoothly and quickly as possible. If you are being evaluated for a painful condition, mark the drawings below according to where you hurt (if it is the back of your neck, mark the drawing on the back of the neck, etc.). If you have any of the symptoms shown on the diagram, indicate where they are by drawing in the appropriate symbol on the affected body part.

B = Burning
S = Stabbing
A = Aching
N = Numbness
P = Pins and Needles





OSTEOPATHIC CONSULTANTS, L.L.C.
BRIAN MOREAUX, D.O. DANIEL SENGENBERGER,D.O.

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Phone: (541) 482-0342 Fax: (541) 482-6986

HIPAA CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

*I, _____ authorize Brian Moreaux, Daniel Sengenberger, Doctors of Osteopathy** to use and disclose my health and medical information for the purposes of Treatment*, Payment*, and Health Care Operations.**

***Treatment:** Includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.*

***Payment:** Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.*

***Health Care Operations:** Includes the necessary administrative and business functions of our office.*

I understand that I have the right to revoke this CONSENT, provided that I do so <u>in writing</u>, except to the extent that the Doctors named above** have already used or disclosed the information in reliance on this CONSENT.

_____ _____ *(or)*
(Date) *(Signature of Patient)*

_____ _____
(Date) *(Signature of Person Authorized by Law)*

OFFICE POLICIES

Osteopathic Consultants, L.L.C.

Brian Moreaux, D.O. Daniel Sengenberger D.O.

PHYSICIANS: The physicians in our office are independent practitioners. Their relationships with insurance companies differ. Thus, fees, billing and payment arrangements may not be the same. Please inquire about the physician's status prior to your appointment with regards to your financial obligation.

INSURANCE: Out of courtesy to our patients we will bill most but not all-insurance companies. **For fees not billed to an insurance company payment is required at the time of service, unless prior arrangements have been made with our office. Copays must be paid at the time of service.** We will not bill insurance companies for durable medical equipment (i.e., splints, braces, etc.).

Osteopathic Manipulative Treatment (OMT) is often administered during your appointment. A few insurance companies do not offer coverage for OMT. We strongly advise you to check your insurance company's policy prior to your first appointment. It will be your responsibility to communicate with your insurance company over disputes. You are ultimately responsible for payment for the services rendered.

CONTACT HOURS: Regular phone hours are 9-12 noon and 1-4 p.m., Monday through Thursday. Our hours may be altered for holiday observances and perhaps other occasions. Hours are posted on our answering machine.

EMERGENCIES: For all perceived life threatening emergencies call 911. For other acute and urgent situations we will make every attempt for you to consult with one of our available physicians. However, the nature of our practice and patient scheduling may not allow for us to provide you with an urgent appointment. If we cannot accommodate you we suggest you contact your primary care practitioner, visit an urgent care facility or go to the emergency department of your choice. For urgent matters after normal hours call our office. You will be directed to one of our physicians through our answering service.

APPOINTMENTS: Our physicians may book up to 90 minutes for new patient appointments, and up to 60 minutes for returning patients. We do NOT "double-book" appointments. Your appointment if YOUR time with your physician. Out of courtesy for others, **we strongly encourage you to arrive early for your scheduled appointment**. Late arrival may inconvenience other patients or limit the time your doctor spends with you. Out of respect for other patients your appointment may be rescheduled if you arrive excessively late. Please check in with our office staff when you first arrive.

Our physicians are very busy and we often have patients on waiting lists for appointments. Therefore, if you need to cancel or reschedule your appointment we require notification 24 hours or more in advance of your scheduled appointment. We reserve the right to bill you directly for missed appointments or appointments in which we have not received at least a 24-hour notice. Insurance companies will not pay for missed appointments.

NEW PATIENTS: If you fail to appear for your appointment, or reschedule less than 24 hours prior to your appointment we will reschedule you only with an advanced cash deposit of approximately 50% of the anticipated fee for your visit. This cash deposit will be credited towards your account.

MEDICATION REFILLS: Medication requests and refills may require 24-48 hours or more (such as weekends and holidays) to review and implement. You must consider this when requesting a refill or change in medication from your physician. The most expeditious way to refill prescriptions is to contact your pharmacy and they will fax your request to our office. On call physicians will not be obliged to provide prescriptions without reviewing your medical records, which is impractical after normal hours.

I have read and understand the above office policies:

_____

Patient signature