OSTEOPATHIC HEALTHCARE OF HALLOWELL

PATIENT REGISTRATION

TODAY'S DATE ________/________/________

PERSONAL INFORMATION

Last Name _________________________ Birthdate ______/_______/______ Age ______

First Name _________________________ Occupation ________________________________

Home Address________________________ EMAIL ________________________________

City/State/Zip ________________________ Preferred Phone# ___________________________

Primary Care Provider__________________ Emergency Contact Name/#___________________

How did you hear about Osteopathic Healthcare of Hallowell? ________________________________

CANCELLATION POLICY

Please let us know at least two business days in advance if you are not able to keep your scheduled appointment. Last minute cancellations and no-shows will be charged $50. Of course, if you have a true emergency (such as injury or a significant illness) the charge will be waived. It is understandable that being late to an appointment is a very real possibility but please be aware that your appointment will have to end on time as a courtesy to the next patient.

PAYMENT

Please understand that Osteopathic Healthcare is a fee-for-service practice, with payment due at the time of service. Dr. Burke is not contracted with Medicare, Medicaid, or any private insurance. A copy of the superbill will be provided upon request and individuals can file it with their insurance company for possible partial or full reimbursement. OMT is typically reimbursed, but please check with your insurance carrier to be sure. Patients with Medicare or Medicaid would not be reimbursed. Please contact the office for payment plans if cost is a barrier to care.

I have reviewed the above Cancellation and Payment policies:

____

Printed(Patient/Parent/Guardian) Signature Date

OSTEOPATHIC HEALTHCARE OF HALLOWELL

INITIAL OFFICE VISIT

Date ________________________

Name ____ Date of Birth _______/______/______

What are your main concerns today? ____

____

When did your symptoms begin? ____

Please describe any trauma, injury or event that may be related to your main concerns_________

____

____

Pain level (please circle) 0 1 2 3 4 5 6 7 8 9 10

Describe the quality of pain: (sharp, achey, numb, burning, shooting, tight, tingling,etc)

____

What makes your symptoms better? ____

____

What makes your symptoms worse? ____

____

Please list other treatments, medications, supplements or procedures you have tried: _________

____

Please list any diagnostic tests such as imaging studies (x-rays, MRI, CT scan, etc.) you have had done related to your main concerns. Please note dates and results as able. You are encouraged to bring a paper copy of any reports with you to your visit.

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

HEALTH INFORMATION CONSENT

I give my consent to representatives of Osteopathic Healthcare of Hallowell to leave messages on my personal answering machine or with individuals designated below.

Relating to my care __________ Yes _____________No

Appointment reminders ___________Yes _____________ No

I give consent to representatives of Osteopathic Healthcare of Hallowell to discuss my care with the following individuals:

____________________________________ (______)___________________________
Partner Name Phone number

____________________________________ (______)___________________________
Family Member/Relationship Phone number

____________________________________ (______)___________________________
Other/Relationship Phone number

I understand and agree that this authorization will stay in effect until I notify Osteopathic Healthcare of Hallowell with written notice to change or withdraw my authorization.

Signature ____ Date ________________________

NOTICE OF PRIVACY POLICIES-ACKNOWLEDGMENT OF REVIEW (HIPAA)

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, as well as follow-up among multiple healthcare providers who may be involved in treatment directly and indirectly. It may be used to conduct normal healthcare operations such as quality assessments and physician certifications. I understand I can obtain a current copy of the Notice of Privacy Practices for Osteopathic Healthcare of Hallowell that explains my rights and the policies and procedures that will safeguard my private health information. I may request in writing that OHH restrict how my private information is used or disclosed and that OHH is not required to agree to my requested restrictions. However, if an agreement is reached, OHH is bound by such restrictions.

Signature____ Date ________________________

PAST MEDICAL HISTORY

Medical Conditions (check box if you have problem listed):

☐ Arthritis	☐ Heart disease
☐ Back/neck pain	☐ High blood pressure/hypertension
☐ Blood Disorders (anemia, abn. clotting)	☐ Intestinal disorders (ulcers,colitis,IBS)
☐ Brain disorders (epilepsy,trauma,etc.)	☐ Kidney disease (cystitis,renal failure)
☐ Cancer, specify:	☐ Liver disease (cirrhosis,hepatitis B or C)
☐ Chronic pain, specify:	☐ Lung disease (asthma,emphysema)
☐ Circulation issues (stroke,phlebitis,etc.)	☐ Mental disorders(depression,anxiety,PTSD)
☐ Diabetes	☐ Migraine/headache
☐ Dystonia (spasms,tremors,Parkinson's)	☐ Multiple sclerosis (neurodegenerative)
☐ Ear problems (tinnitus,hearing loss)	☐ Prostate disease
☐ Eating disorder (anorexia,bulimia)	☐ Rheumatic disorder (lupus,Sjogren's, RA)
☐ Endocrine problems (thyroid,hormones)	☐ Skin disorder (psoriasis,eczema)
☐ Eye problems (glaucoma,cataracts)	☐ Sleep disorder (insomnia,sleep apnea)
☐ Genital/GYN problems	☐ Substance abuse (tobacco,alcohol,drugs)
☐ Other	☐ Other

FEMALE REPRODUCTIVE HISTORY

Number of pregnancies______ Number of Children ______ Current Ages of Children ____________

Methods of Birthing ______________ Birthing Complications ________________________________

Prenatal issues ____________________________ Postpartum issues _____________________________

SURGICAL HISTORY (PLEASE LIST DATES)

____ ____

____ ____

____ ____

____ ____

____ ____

FAMILY MEDICAL HISTORY (CHECK BOX)

Check here if adopted ___________

	alive age	deceased age	heart disease	HTN (highBP)	stroke	diabetes	cancer	substance abuse	mental disorder	arthritis	other
mother											
father											
MGM											
MGF											
PGM											
PGF											

Ages and health of sisters, brothers, children:

_____ ____________________________________ ______ __________________________________

_____ ____________________________________ ______ __________________________________

_____ ____________________________________ ______ __________________________________

SOCIAL HISTORY/HABITS

	Amount	Frequency	#Years	Quit date	Never
Smoking:	______________	_______________	_______	____________	______
Alcohol:	______________	_______________	_______	____________	______
Drugs:	______________	_______________	_______	____________	______
Caffeine:	______________	_______________	_______	____________	______
Exercise:	______________	_______________	_______	____________	______

*Do you feel safe at home? ____

TRAUMA

Check here if none ________

Head trauma/concussion: ____

Motor vehicle accidents: ____

Injuries (sports/falls,etc.): ____

Physically demanding activities (sport/arts/crafts/job): _______________________________________

Dental work (extractions,braces): ____

Birth issues: ____

Emotional trauma: ____

Other: ____

MEDICATIONS

Please list dose/frequency of any medications/supplements/herbs/vitamins:

____ ____

____ ____

____ ____

____ ____

____

ALLERGIES/SENSITIVITIES:____

AUTHORIZATION FOR OHH TO OBTAIN CONFIDENTIAL MEDICAL RECORDS

I hereby authorize Osteopathic Healthcare of Hallowell to obtain records from:

Physician/Healthcare Provider ____

Address ____

Phone ____________________________________ Fax ________________________________

_______ X-ray/MRI ______Labs only _______Office Notes only _______Other

Printed(Patient/Parent/Guardian) Signature Date

AUTHORIZATION FOR OHH TO OBTAIN CONFIDENTIAL MEDICAL RECORDS

I hereby authorize Osteopathic Healthcare of Hallowell to obtain records from:

Physician/Healthcare Provider ____

Address ____

Phone ____________________________________ Fax ________________________________

_______ X-ray/MRI ______Labs only _______Office Notes only _______Other

Printed(Patient/Parent/Guardian) Signature Date

DIRECTIONS

The office is located at 40 Water Street in Hallowell at the corner of Wilder Street and Water Street. The office is reached by turning into Wilder Street and taking two rights to get into the parking area. Please use the entrance facing Water Street.

From the South(295):

Take Exit 51 and turn right onto 126/9 and follow into Gardiner. At the first set of lights turn left onto Bridge Street. Stay in the left lane to turn left onto 201/27/Maine Ave. and travel 4.5miles through downtown Hallowell. The office is in the front of a yellow Victorian house about ¼ mile beyond the downtown area.

From the East/North:

Travel south on State Street/201 from Memorial Circle in Augusta. After 1.4 miles turn left onto Wilder Street.

From Route 95N:

Take Exit 112 for 8/11/27 toward Augusta. Use the left two lanes to turn left onto 11/27/8/Civic Ctr. Drive/New Belgrade Rd. At the traffic circle take the second exit onto State Street. Go straight through the circle onto State Street and travel 1.4 miles. Turn left onto Wilder Street

OSTEOPATHIC HEALTHCARE OF HALLOWELL CONSENT FOR OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)

What is OMT?

OMT is a non-invasive manual medicine treatment that focuses on total body health by treating and strengthening the musculoskeletal framework including the joints, muscles, and spine. The goal of treatment is to enhance the body's nervous, circulatory, and immune systems. This treatment is a holistic(whole body) approach to health care. Osteopaths do not simply concentrate on treating the problem area, but use manual techniques to balance all the systems of the body, to provide overall good health and wellbeing. As this is a hands-on treatment, your osteopath will likely touch areas of your body including, but not limited to, your head, spine, pelvis, tailbone, and limbs.

Benefits of Osteopathy

Potential benefits of OMT include reduction of pain or discomfort, greater flexibility and strength, restoration of symmetry, improvement in numbness or tingling, reduction of swelling, enhancement of the body's natural healing mechanisms, and improvement in function of the body's organ system.

Possible Side Effects

OMT is generally very safe, painless, and without complications. Mild soreness lasting 2-7 days after treatment is possible, and is usually considered a normal part of the healing process. Most commonly drowsiness, headache, or a lightheaded feeling may occur temporarily. Serious side effects(fracture, disc herniation, and blood vessel injury) are extremely rare-they have been reported as occurring in between 1 in 400,000 to 1 in 5.85 million patients undergoing cervical spine high velocity thrusting manipulation. In comparison, NSAIDS, such as Advil, have an estimated risk of serious side effects(e.g. peptic ulcer, GI bleed, death) of 1 in 1000 patients. As in any form of medicine, unexpected risks or complications may occur.

Acknowledgment

I acknowledge that I have read the above description about OMT, and understand possible risks and benefits of the OMT. I have informed the physician of any previously diagnosed conditions that may affect the treatment outcome. I understand that Osteopathic Healthcare of Hallowell will not be providing routine internal medicine/family practice care for me and I am advised to have a primary care provider for acute and chronic medical care. I understand there is no guarantee that OMT will resolve my symptoms. I consent to the performance of OMT at Osteopathic Healthcare of Hallowell.

Signature ____

Print Name ____ Date ______________________