Scoville Osteopathic Healthcare, P.C.
10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330

Patient Registration

(Please Print Clearly) Today's Date ____/____/_____

Patient's Full Name _____Date of Birth ____/____/_____

Marital Status: S M D W Gender: M F NB Pronouns: _____

Address_____City_____State_____ Zip_____

Phone #s: Home ( ) _____Work ( ) _____Cell ( ) _____
Please circle which number is best to call home/work/cell May a private voice message be left for you? YES/ NO

Guardian for child_____Relationship_____Phone_____
Address (if different)_____

Patient's Employer_____E-mail:_____
(Note that email generally and use of employer's email is not private.)
Address_____City_____State_____ Zip_____

Preferred method of contact: (circle one) phone call email USPS mail

Spouse's/Partner's Name _____
Spouse's/Partner's Employer_____ Daytime # ( ) _____
Emergency Contact _____ Phone # ( ) _____
(Other than Spouse/Partner)

Is there anyone you with whom you want us to share your medical information?

_____ _____
Name & relationship Name & relationship

Is there anyone with whom you do <u>not</u> want us to share your medical information ?

_____
(The Doctor is not required to honor your request if it is not in your medical best interests. Please discuss this with the doctor.)

<u>Financial Information</u>

Financially Responsible Person _____ Relationship_____
Address (if different) _____ City_____ State_____ Zip_____
Are you covered under Medicare? Y or N Medicare # _____

Primary Health Insurance Company:

_____
Identification # _____
Group # _____
Subscriber_____
Subscriber's Date of Birth _____/_____/____
Effective Date _____

Secondary Health Insurance Company:

_____
Identification # _____
Group # _____
Subscriber_____
Subscriber's Date of Birth _____/_____/_____
Effective Date _____

Primary Care provider and phone number_____
Referred by: _____

Please continue onto next page and sign.

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Patient Registration (continued)

FINANCIAL POLICY: I certify that the information I have reported is correct. I acknowledge that it is the policy of this office to collect full payment at the time of each visit. I understand that I am financially responsible for services provided. This office does not participate with health insurance, including Medicare or Medicaid, or provide workers compensation or disability reports. In addition, I agree that in the event I do not pay for services provided, I will pay for the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that in the absence of a payment plan, outstanding balances may accrue 1.5% interest per month after 30 days.

CONFIDENTIALITY: As your physician, it is necessary to communicate in writing, by phone, fax or electronic communication to your primary care physician, or other health care providers, health insurance companies, Medicare/Medicaid or health claims clearinghouses. Communication between your doctors is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information about you be sent to them and you have agreed to release this information as a participating member. The practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal health information for marketing and fundraising purposes.

I understand and agree that my personal health information may be transmitted by computer to laboratories and or consulting health care practitioners to facilitate my medical care. I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices and Health Care Disclosure Information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated and I will be able to see the new information. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines.
A copy of this form can be considered as valid as the original.

CONSENT TO TREATMENT: We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above office policies and consent to treatment by Dr. Scoville and her staff.

Signature of Patient_____ **Date** _____
or Authorized Guardian if under 18 years old

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Office Policy

Welcome:

To help you get acquainted with the office, we have prepared this statement about our policies and fee schedules. Please sign below to indicate that you have read and understand our guidelines.

Office Hours:
Sat 9:00 am – 5:00 pm at **temporary address: 8609 Second Avenue, Suite 405B, Silver Spring, MD 20910**

Your Appointment:

Your appointment is time set aside for you to see the Doctor. We have a ***twenty-four (24) hour cancellation policy***. If you cancel an appointment less than 24 hours prior to its scheduled time, you will be billed the full visit fee. A message may be left on our voice mail at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and will make every effort to be punctual for your appointment.

Children:
Children *must be supervised by their caretaker and remain in the waiting area* unless they are being seen by the doctor.

Fragrances:

Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays; we would appreciate it if you would refrain from wearing these to the office.

Fees & Payments:

For all patients, we require payment for services at the time they are provided. We do not participate with private insurance carriers, but we supply a standard, itemized receipt that you may submit to your non-Medicare insurance company to request reimbursement. Our practice also does not participate with Medicare or Medicaid. Because Dr. Scoville has opted out of Medicare, Medicare patients will need to sign a Private Pay Contract, which the doctor will explain prior to treatment. The Contract affirms that the patient accepts responsibility for all treatment costs, and will not seek Medicare reimbursement.

The parent or guardian of a minor patient is responsible for payment.

Checks returned from the bank will incur a $30.00 “returned check” fee to your account.

Thank you for taking the time to read this policy sheet. If you have any questions about our policy please ask them now.

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Name:_____

HISTORY OF CURRENT ISSUE

1. What problems cause you to consult the doctor today? (Describe your symptoms in detail.)

_____

_____

2. When did your symptoms begin? _____

3. Do you know what caused them? If so please explain. _____

4. If you have pain, has it increased or decreased since the onset? _____

5. What has helped relieve your symptoms? _____

6. What time of day are your symptoms most severe? _____

7. How many days a week do you experience your symptoms? _____

8. What type of treatment, medical or non-medical, have you received for this problem? _____
_____

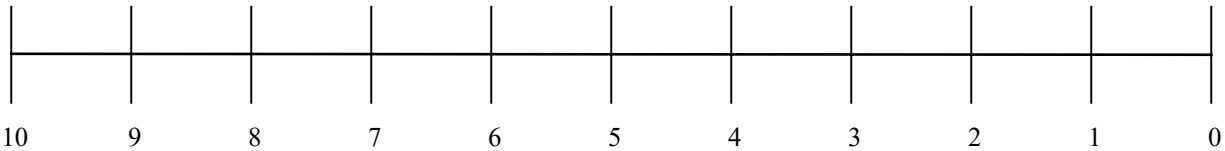
9. How has this pain affected your life, at work, at home, and socially? _____

_____

TO WHAT EXTENT DOES PAIN OR PROBLEM AFFECT YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES:

Activity	0%	25%	50%	75%	100%	Activity	0%	25%	50%	75%	100%
Shampoo your hair						Stand					
Fasten buttons						Sleep					
Put on and tie shoes						Socialize					
Cut toe nails						Travel in a car					
Lift objects less that 20 pounds						Fulfill your job requirements					
Walk for > 15 minutes						Do laundry					
Sit in a car						Shop for groceries					
Lie down in bed						Gardening					

If "10" = worst and "0" = no problem, on the scale below where you would rate yourself today:



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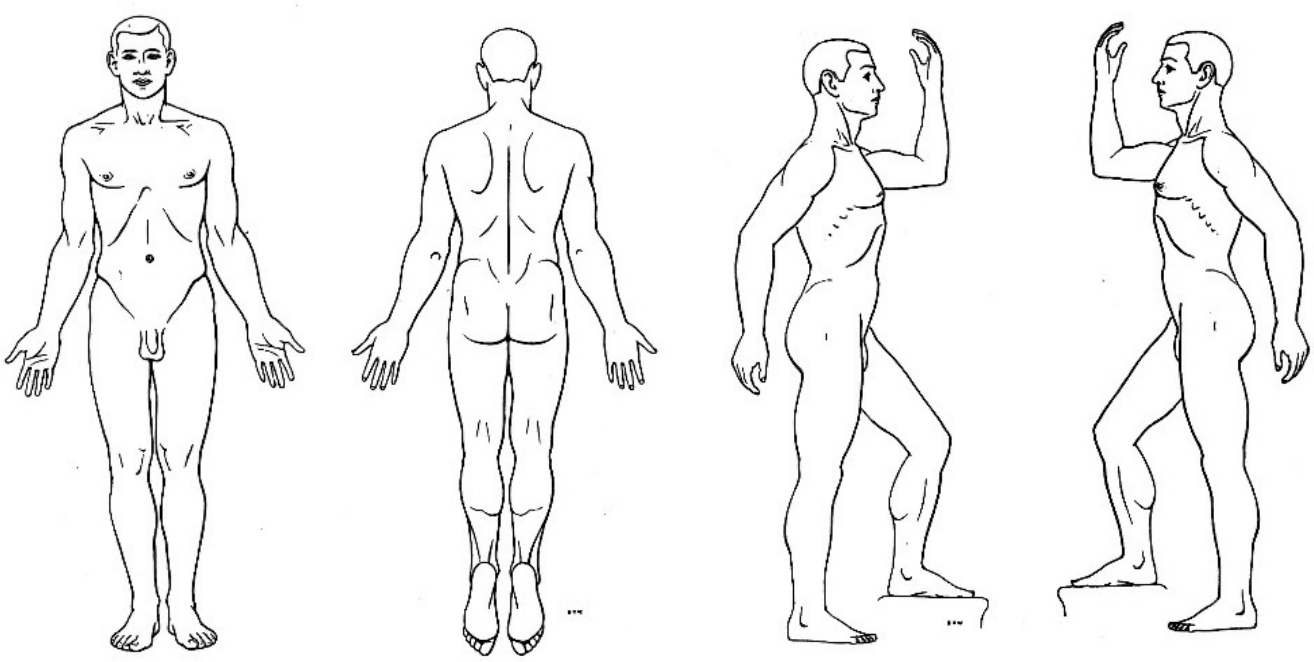
Name: _____

LOCATE YOUR PAIN ON THE FIGURES BELOW, USING THE SYMBOLS GIVEN BELOW:

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	+ + +



SOCIAL HISTORY

Highest education level:
Occupation:
Military service: Yes No If yes, where?
Travel: (Type and frequency)
Hobbies:
Exercise program:
Alcohol Consumption: Amount per week and years used?
Drug use:(Marijuana, Heroin, LSD, Cocaine, Methamphetamine): Amount and how long used?
Tobacco use: How much per day and how many years used?
Caffeine consumption: (coffee, tea, carbonated soft drink, energy drinks) How many ounces per day?

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Name: _____

PATIENT MEDICAL HISTORY

PAST MEDICAL ISSUES: _____
_____
_____

MEDICATIONS YOU ARE CURRENTLY TAKING: (prescription and over the counter)

Name	Dosage	Frequency	Years Used
1.			
2.			
3.			
4.			
5.			

Please use back of page if needed.

ALLERGIES TO:	What symptoms did you have with the reactions?
1. Drugs:	
2. Foods:	
3. Chemicals and Environmental Factors:	
4. Animals:	

OPERATIONS AND/OR ILLNESSES REQUIRING HOSPITALIZATION:

_____ Year _____
_____ Year _____
_____ Year _____

INJURIES (severe sprains, fractures, dislocations) OR BONE/JOINT PROBLEMS:

_____ Year _____
_____ Year _____
_____ Year _____

RECENT RELEVANT STUDIES OR TESTS:

_____ Year _____
_____ Year _____
_____ Year _____

OTHER HEALTHCARE PROVIDERS:

_____ Specialty _____
_____ Specialty _____
_____ Specialty _____

IF FEMALE, ARE YOU PREGNANT NOW? _____

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FAMILY HISTORY

Please indicate which of your family members have had: Allergies, Bleeding Tendencies, Cancer (give location and type), Diabetes, Epilepsy, Heart Disease, High Blood Pressure, Kidney Disease, Mental Illness, Lung Disease, Stroke, or Tuberculosis.

Relative	Age if Living	Health Problem	Age of Onset	Age of Death	Cause of Death
Paternal GM					
Paternal GF					
Maternal GM					
Maternal GF					
Father					
Mother					
Brothers					
Sisters					
Children					

REVIEW OF SYSTEMS

Indicate "C" if it is a current problem and "P" if it is a past problem

C	P	1. SKIN:	C	P	3. HEAD:	C	P	4. EYES: (continued)
		Color change			Trauma			Color blindness
		Texture change			Headache			Glaucoma
		Moisture Change			Dizziness or light-headed			Cataracts
		Sores			Fainting			Wear glasses/contacts
		Itching			Loss of consciousness			Date of last refraction
		Severe acne			Feeling of spinning	C	P	5. Ears (R or L or Both?)
		Cancer			Seizure disorder			Hearing loss
		Easy bruising/bleeding	C	P	4. EYES (R or L or Both?)			Use of hearing aid(s)
		Change in Fingernails			Itching			Ringing in ears
		Hair loss/distribution			Watering or dryness			Ear pain
		Oiliness (skin, hair, scalp)			Discharge or crusting			Discharge
C	P	2. LYMPHNODES: (B or L?)			Double vision			Excess wax
		Enlargement			Sensitive to light			Recurrent infections
		Redness (inflammation)			See halos around light or floaters			Mastoiditis
		Pain or tenderness			Change in vision			Motion sickness

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Name:_____

REVIEW OF SYSTEMS (cont.)

C	P	6. NOSE:	C	P	9. CARDIOVASCULAR	C	P	11. GASTROINTESTINAL (cont.)
		Trauma			Blood clots in the lungs			Bowel movements during night
		Sinusitis			High blood pressure			Constipation
		Excess nasal drainage			Chest pressure or tightness			Straining with bowel movements
		Stuffiness			Chest pain or heaviness			Diarrhea
		Obstruction			Chest discomfort (exertional)			Use of antacids or laxatives
		Post-nasal drainage			Palpitations			Black stools
		Nosebleed			Rapid heart rate at rest			Grey or yellow stools
		Smell (decrease or loss of)			Irregular heart rate			Rectal pain or discomfort
		Mouth breather			Heart murmur			Rectal itching
		Frequent colds			Swollen ankles/feet in evening			Hemorrhoids
		Snoring			Leg cramps when sleeping			Rectal bleeding
C	P	7. MOUTH / THROAT/ NECK			High cholesterol or fats			Anal Fissures
		Trauma			Blue hands or feet			Hernia (umbilical or hiatal)
		Sores in mouth			Calf pain while walking			Yellow skin (jaundice)
		Bleeding or infected gums			Cold hands or feet			Gall stones or GB disease
		Sore tongue	C	P	10. BREASTS (R or L or both)			Pancreatitis
		Dental cavities			Pain and tenderness	C	P	12. URINARY TRACT:
		Frequent sore throats			Swelling			Difficulty / inability to urinate
		Difficulty swallowing			Lumps or masses			Infrequent, sm. Amt. of urine
		Persistent hoarseness			Nipple retraction			Frequent urinary tract infections
		Change of taste			Nipple discharge or bleeding			
		Bad breath			Frequency of self-examination			Flank pain
		Big tonsils / adenoids	C	P	11. GATROINTESTINAL			Kidney infection / nephritis
		Thyroid enlargement			Wt. loss/gain in the last year			Kidney or bladder stones
		Neck pain or tenderness			Loss of appetite			Hernia: L or R inguinal or femoral
C	P	8. RESPIRATORY			Compulsive eater			
		Asthma			Stomach / duodenal ulcers			Sexually transmitted disease
		Pneumonia			Heartburn			Sexual problems you wish to Discuss with the doctor?
		Bronchitis			Indigestion			
		Emphysema			Food intolerances			Frequent urination
		Cough			Bloating or belching			No. of times you urinate at night
		Sputum (amount and color)			Flatulence (passing gas)			Cloudy urine
		Cough up blood			Nausea			Dribbling
		Shortness of breath (@ rest)			Vomiting			Urgency / loss of control
		Shortness of breath (exertion)			Vomiting blood			Hesitancy

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Name:_____

REVIEW OF SYSTEMS (cont.)

C	P	19. OB / GYNECOLOGY:	C	P	14. MALE GENITALIA (cont.)	C	P	16. PSYCHOLOGICAL (cont.)
		When was the first day of Your last period?			Sexual dysfunction or impotence			Problems (with spouse / family)
								Previous psychiatric care
		At what age did you have Your first menstrual period?			Testicular mass (R or L?)			Do you desire psychiatric care?
					Decreased force of urinary stream			Cry often
		How many days do you Flow?						Worrier
					Difficulty starting or Stopping flow of urine			Perfectionist
		Menstrual cramps						Difficulty making decisions
		Hot flashes	C	P	15. NEUROLOGICAL:			Consider / attempted suicide
		Painful intercourse			Head injury			Difficulty sleeping
		Vaginal discharge			Frequent headaches	C	P	17. MUSCULOSKELETAL
		Vaginal dryness			Loss of consciousness			Trauma (fracture / dislocation)
		Sores on external genitalia			Fainting			Car accident
		Infertility problems			Numbness (location?)			Decreased range of motion
		Breast feeding			Tingling (location?)			Loss of strength
		Contraceptive use: (type?)			Weakness (location?)			Stiff or aching muscles / joints
		No. of pregnancies			Tremors			Neck ache / pain
		No. of live births			Convulsions			Backache / pain
		No. of living children			Twitching			Arm or hand pain
		No. of abortions (miscarriages)			Difficulty walking			Numbness / tingling (where?)
		Complications (with pregnancies or deliveries)			Speech abnormalities			Sciatic pain (R or L?)
					Decrease / loss of sensation			Arthritis
C	P	14. MALE GENITALIA:			Sleep disturbances			Swollen joints
		Urethral discharge	C	P	16. PSYCHOLOGICAL			Join pain
		Sores on penis or scrotum			Nervousness / anxious			Blow to the head
		Testicles tender (R or L?)			Sensitive			A fall on your buttocks?
		Enlarged prostate			Depressed			
		Prostatitis			Fatigue			
		Elevated PSA			Memory change			

For Physician's use:
