Patient Demographic Form

Last Name _____ First Name_____ MI_____

Street Address _____ City/State/Zip _____

Home # (____)_____ Work # (____)_____ Cell # (____)_____

SS #_____-____-_____ DOB ____/____/_____ Age _____ Male / Female

Race: American Indian or Alaskan Native / Asian / Black / Caucasian / Other / Pacific Islander / Declined

Ethnicity: Hispanic / Non-Hispanic / Declined

Language: English / Spanish / Other / Arabic / Cantonese / French / German / Hindi

Emergency Contact _____ Tel # (____)_____ Relation _____

Name of referring Provider _____ Primary Care Physician _____

Insurance Information

Name of Primary Insurance _____ City/State/Zip _____

Policy # _____ Group # _____

Name & Address of Subscriber _____ City/State/Zip _____

Relationship to Patient _____ Tel # (____) _____

Name of Secondary Insurance _____ City/State/Zip _____

Policy # _____ Group # _____

Name & Address of Subscriber _____City/State/Zip _____

Relationship to Patient _____ Tel # (___) _____

Employment Information

Employer Name & Address _____ City/State/Zip _____

Tel # (____) _____ Ext _____ Title _____

Consent for Payment to Iannetta Osteopathic Manipulation

I authorize payment of my medical benefits to Iannetta Osteopathic Manipulation for services rendered. I understand that I am financially responsible for my insurance co-pay at time of office visit and in the event that payment is denied or rejected by the insurance company and for those charges not covered by my policy benefits. This included deductibles and co-insurances that are not covered by this agreement.

Missed appointments with less than 24 hour notification will be subject to a $50 cancellation fee.

_____ _____

Signature of patient or legal guardian Date

(Rev. 2/13/2012)

REVIEW OF SYSTEMS

Patient Name _____ MR# _____ Date _____

Please circle the symptoms you are having and fill in the blanks:

GENERAL:
Weight Change
Concerns about weight
Fatigue
Fever
Problems with sleep
Chills
Sweats

ENT:
Eye Problems
Date of last eye exam_____
Nose Problems
Throat Problems
Ear/hearing problems
Allergy symptoms
Date of last dental visit_____

BREAST:
Lumps
Pain
Discharge
Do Breast self exam? Y / N
Date of last Mammogram_____

RESPIRATORY:
Cough
Wheezing
Shortness of Breath
Exposure to TB

CARDIOVASCULAR:
Chest pain or Pressure
Palpitations

GASTROINTESTINAL:
Heartburn
Pain
Bowel habit changes
Diarrhea
Trouble swallowing
Constipation
Blood in bowel movement

GENITOURINARY:
Pain with voiding
Change with Urinating frequency
Sexual Problems
Inability to hold urine/leaking

MEN: Pain in genitals
lumps
Discharges
Hernia
Perform testicular self exam? Y / N

WOMEN:
Date of last period_____
Menstrual Problems
Pain
Date of last pap _____
Vaginal dryness
Hot flashes
Discharge
Concerns about menopause
Method of birth control
_____

MUSCULOSKELETAL:
Back Pain
Leg or arm pain
Joint pain
Joint swelling

SKIN:
Rashes
Itching
Changing moles
Acne
Non-healing sores

EMOTIONAL:
Anxiety
Depression
Panic Attacks

NEURO:
Headache
Blackout
Numbness
Tremors
Weakness

BLOOD:
Anemia
Swollen Glands
Concerns about AIDS/HIV

Any other concerns today:

_____

_____

Medical Provider's Signature: _____

Date: _____

Informed Consent to Osteopathic Care

Joshua Iannetta D.O.
632 US Route 1
Scarborough, ME 04074
Ph (207) 883-1003
Fax(207) 883-5322

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of osteopathic treatments, manipulations, and other osteopathic procedures on me by Dr. Iannetta.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of osteopathic treatments.

Though osteopathic treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are risks to treatment. I know that medicine and treatment have risks and some treatment and tests may cause harm.

I understand that I will be receiving the following treatment:

Osteopathic Manipulation
_____
_____
_____

I understand that osteopathy is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that I have no guarantee and no assurance has been made by anyone regarding the osteopathic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

Doctor's Signature _____ Date _____

Notice of Privacy Practices
Patient Acknowledgement

Patient Name _____ Date of Birth _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes; treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature _____ Date _____

Relationship to patient (if signed by a personal representative of patient) _____

MEDICAL HISTORY INTAKE FORM

Name _____ Age _____ Date of Birth _____

Person giving history _____ Today's date _____

Allergies to medications (please list) _____

_____

Medications: Name, dosage and how many times a day. Include over the counter medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Hospitalizations and surgeries (Please list with dates)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Trauma History (injuries or accidents, please include dates)

1. _____
2. _____
3. _____
4. _____

Birth history (circle one) Were you born by C-Section, Forcep delivery, Vacuum delivery, quick or slow birth, don't know?

Medical Problems

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Social History

Do you smoke? Y____ N ____ If yes, how many packs per day? ____ Age you began smoking ____

Did you ever smoke? Y____ N ____ If yes, when did you quit? _____

Do you drink alcohol? Y ____ N ____ If yes, number of drinks per week (include wine) _____

Do you use drugs? (other than those prescribed for you) Y ____ N ____
If yes, what type and amount _____

Number of cups of coffee, tea and cola per day _____ Marital Status _____

Occupation _____ Hobbies _____

Members of your Household _____

Last grade completed _____

Family History

Father: Age if living _____ Health Problems _____
If deceased age at death _____ Cause _____

Mother: Age if living _____ Health Problems _____
If deceased age at death _____ Cause _____

Number of brothers _____ Health problems _____

Number of sisters _____ Health problems _____

Spouse age _____ Health _____

Children: Name, ages and Health _____

_____

Circle if present in any blood relatives (include parents, grandparents, brothers, sisters, children, cousins, aunts and uncles): Diabetes, Cancer, High blood pressure, Heart disease (including heart attack), Lung disease, Tuberculosis, Epilepsy, Psychiatric illness, Migraine headaches, Arthritis, Suicide, Kidney disease, Glaucoma, Blood disease, Alcohol or Drug abuse.

Other inherited conditions _____