**NEW PATIENT INFORMATION and CONSENT FORM**

Form and Function Osteopathic Medicine
Kris Sornberger Osteopathic Healthcare, PLLC
One Cumberland Place Suite 112
Bangor ME 04401
Phone and text: 207-307-0816
Fax: 207-433-1050
email: FormFunctionOsteopathic@gmail.com

**Date:**_____

Patient's Name_____ M___ F___ Birthdate_____Age_____

If patient is a minor or has guardianship, Name of person filing out form: _____

Patient's address: _____

City_____State_____Zip_____

Email: _____

Phone: home_____ cell_____ ***Text appointment reminders: (circle) YES NO***

Social: Single___ Married___ Other___

Occupation:_____Employer:_____

Primary Care Physician : _____

PCP Location: clinic and town/state _____

Emergency Contact Info: Name: _____ Relationship: _____ Phone: _____

**Insurance coverage primary**_____ ID #_____ Group #_____

Insurance coverage secondary _____ ID #_____ Group #_____

Work Related Injury: **YES NO** Claim #_____Date of Injury_____ Insurance carrier_____

Motor Vehicle Accident Injury:**YES NO** Claim #_____Date of Accident_____ Insurance carrier_____

**I understand and agree to the following:**

I understand that the Medical Practice accepts *all forms of insurance payment*. However, payment for services rendered at the Practice is solely my responsibility, regardless of any insurance coverage I may have. I am financially responsible for payments that are denied or rejected (after the Practice has made all good-faith attempts to obtain payment from the insurance company) by the insurance company and for those charges not covered by insurance policy benefits, such as deductibles, co-insurance, and co-pays. Osteopathic Manipulation is considered a therapeutic procedure and can result in a second charge to the insurance, in addition to the office visit charge. There may be two separate charges to the insurance associated with your visit today.

I authorize the release of any medical records and/or any other pertinent information necessary to obtain payment for services to any insurance organizations or its affiliates, and authorize release of records to any medical review agencies or other agencies as required.

I voluntarily and knowingly consent to and request any type of outpatient treatment, which may include Osteopathic Manipulation Therapy (OMT) and other types of medical treatments deemed appropriate by the treating physician. I understand that such services are to be performed by the attending physician. I understand that OMT is a hands-on therapy that has risks and benefits. Some risks are increased pain or soreness after the OMT is completed. I have verbally consented to have OMT preformed as a non-invasive, conservative therapy to treat my acute and chronic conditions.

I understand that Form and Function Osteopathic Medicine, Kris Sornberger, DO is not a Primary Care Provider (PCP) and that my visit with said doctor is for specialty services only.

_____ _____

**Signature of patient, parent or guardian** **Date**

## Receipt of Notice of Privacy Practices Written Acknowledgement Form

Form and Function Osteopathic Medicine
Kris Sornberger Osteopathic Healthcare, PLLC
One Cumberland Place
Suite 112
Bangor ME 04401
Phone: 207-307-0816

I am a patient or parent or guardian at Form and Function Osteopathic Medicine Practice. I hereby acknowledge receiving and reading of Form and Function Osteopathic Medicine's Notice of Privacy Practices information.

Name :_____

Signature: _____ Date: _____

Relationship (check one) Patient: _____ Parent:_____ Legal Guardian:_____

## Authorization of Communication Via Email and/or Text Message

I authorize Form and Function Osteopathic Medicine to communicate with me via:

**circle one or both: email text**

for the purpose of confirming appointments, rescheduling appointments, and any other general pertinent information that the medical practice may need to inform me of. I also consent to receiving via email or text receipts for payment for any services rendered at The Practice. I understand that email and text may not be a secure method of communication. I understand that I may opt out of emailed or text communication any time.

_____ Date: _____
Signature

NEW PATIENT HEALTH HISTORY
Form and Function Osteopathic Medicine
Kris Sornberger Osteopathic Healthcare, PLLC
One Cumberland Place Suite 112
Bangor ME 04401
Phone and text: 207-307-0816
Fax: 207-433-1050
email: FormFunctionOsteopathic@gmail.com

Date:_____

Name: _____DOB:_____ Age: _____

Primary Care Physician: _____Clinic Name and Location:_____

Medical problem that brought you here today?

_____
_____

Other associated type of symptoms you are having?

_____
_____
_____
_____

MEDICAL History and other medical Problems:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Surgical History:

_____ _____ _____
_____ _____ _____

ALLERGIES: _____

Medications- name only:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking? _____ If so, how much per day? _____

How much Exercise per week and what kind? _____

Other Hobbies and activities: _____

MEDICAL HISTORY in your family :

Mother_____

Father _____

Siblings_____

Other_____

REVIEW OF SYMPTOMS: Check off any of the following symptoms you have/had *RECENTLY* experienced within the last few WEEKs:

GENERAL:

___ weight gain/loss
___ tired/weak
___ dizzy/fainting
___ fever/chills

ENT:

___ headaches ___ hearing loss ___ noise in ears ___ blurry vision
___ eye pain ___ stuffy nose ___ nosebleeds ___ earaches
___ runny nose ___ bleeding gums ___ sore throats

RESPIRATORY:

___ cough ___ cough with phlegm ___ cough with blood ___ wheezing ___ short of breath

HEART:

___ high blood pressure ___ heart races or skips beats ___ chest pain ___ short of breath after climbing steps
___ short of breath while laying in bed ___ legs swell ___ legs hurt or cramp when walking ___ varicose veins

GI:

___ trouble swallowing ___ heartburn ___ poor appetite ___ nausea ___ vomiting ___abdominal pain
___ diarrhea ___ constipation ___ excess belching or passing gas ___ change in stool

URINARY:

___ burning with urination ___ frequent urination ____ change in urine stream
___ frequent urinary infection ___ lose urine if you cough or sneeze ___ kidney stones

MUSCULOSKELETAL:

___ pain in muscles or joints ___ morning stiffness ___ backache ___ sciatica ___ low back pain ___ arthritis
___ gout ___ scoliosis ___muscle spasms

NEUROLOGICAL:

___ blackouts ___ seizures ___ numbness or loss of sensation ___ tingling or "pins and needles"
___ tremors or other involuntary movements ____ weakness in arms or legs ___ trouble walking

ENDOCRINE:

___ heat or cold intolerance ___ excessive sweating ___ excessive thirst or hunger ___excessive urination

PSYCHOLOGICAL:

___ anxiety ___ tension ___depression ___ difficulty with memory ___confusion

DERMATOLOGICAL:

___ skin changes / rash ___ Bleeding ____ Bruising_____non-healing wounds

*Other Pertinent Information you wish the Doctor to know:*

_____
_____
_____
_____