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

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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: ENT:

___ weight gain/loss ___ headaches ___ eye pain ___ runny nose
___ tired/weak ___ hearing loss ___ stuffy nose ___ bleeding gums
___ dizzy/fainting ___ noise in ears ___ nosebleeds
___ fever/chills ___ blurry vision ___ earaches ___ 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:

____
____
____
____