

**NEW PATIENT INFORMATION and CONSENT FORM**

Form and Function Osteopathic Medicine

Kris Sornberger Osteopathic Healthcare

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.**

**There is a \$50 fee for no showing an apt and for canceling with less than 24 hrs notice.**

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 performed 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 the 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  
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.

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 billing statements and receipts 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.

\_\_\_\_\_  
Signature

NEW PATIENT HEALTH HISTORY  
Form and Function Osteopathic Medicine  
Kris Sornberger Osteopathic Healthcare  
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  
 fever/chills

ENT:

headaches  
 hearing loss  
 noise in ears  
 blurry vision  
 eye pain  
 stuffy nose  
 nosebleeds  
 earaches  
 congestion  
 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     neck pain     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:*

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