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:_____ Date:_____

HISTORY OF CURRENT ISSUE

What problem(s) lead you to consult the doctor today? (Describe symptoms in detail.)

_____

_____

_____

When did symptoms begin? _____

Do you know what caused the symptoms? If so, please explain. _____

_____

How often are symptoms present? _____

How long do symptoms last? _____

What time of day are symptoms more prominent? _____

Does the child appear to have pain? ____ If so, has it increased or decreased? _____

What makes symptoms better? _____

What makes symptoms worse? _____

Has the child had any of these problems in the past? _____

What type of treatment, medical or non-medical, has the child received before for this issue? _____

_____

_____

What previous diagnostic tests or studies have been done? Results? _____

_____

_____

Has this issue affected the child developmentally or socially? If so, how? _____

_____

_____

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Name:_____ Date:_____

PAST MEDICAL HISTORY

Please list all past illnesses/hospitalizations:

_____ Date _____
_____ Date _____
_____ Date _____

Please list any operations:

_____ Date _____
_____ Date _____
_____ Date _____

Please list current medications:

Name	Dose	Taking Since	Effect

Please list any allergies and type of reaction:

_____
_____
_____

Please list any traumas/accidents/injuries:

_____
_____
_____

PRENATAL & BIRTH HISTORY

(Please circle appropriate choices when given.)

___ of___ siblings; Pregnancy welcomed /planned: Yes No ; Prenatal care?_____

Medicines/ caffeine /tobacco/alcohol/substances used during pregnancy:_____

_____

Complications with Pregnancy: _____

Gestational age/weeks pregnant at delivery: _____Type of delivery_____

Time of ruptured membranes_____

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Name:_____ Date:_____

Hours of Labor/Problems: _____

Time Pushing: _____Medicines used:_____

Epidural: Yes No Pitocin augmentation: Yes No Forceps or vacuum: Yes No

C-Section: Yes No Reason: _____

Presentation: Vertex Breech Transverse ; APGAR scores_____/_____

First Cry: strong weak Birth weight: _____ Birth length:_____

Complications Mother:_____

Complications Baby: _____

Feeding:

Immediately to breast? Yes No Breast/Bottle ; Suck strong: Yes No ; Spit-up: Yes No

Vomit: Yes No ; Failure to thrive: Yes No ; Formula name_____ changed? Yes No

Colic: Yes No ; Sleeps well: Yes No ; Start solids: Yes No ; Feed self: Yes No

Personality_____

Was baby placed on belly as infant? Yes No

DEVELOPMENTAL HISTORY

Milestone:	Age:	Milestone:	Age:
Chest up in prone (often approximately 2m)		Coos, Smiles (2m)	
Up on hands, rolls front/back (4m)		Reaches, laughs, vocalizes after speaker (4m)	
Rolls back/front, lifts head (5m)		Smiles in mirror, object hand to mouth, mimic (5m)	
Sit supported (6m)		Babbles, strangers, looks to floor for fallen object	
Sits unsupported (7m)		Bangs/shake, toy, feet to mouth, (7m)	
Gets into sitting position (8m)		Peek-A-Boo	
Pulls to stand, creeps, grasp with fingertips (9m)		Words have meaning	
Walk with hands held, pincer grasp (10m)		Look at picture in book (10m)	
Stands alone (11m)		Looks for person named, First word (11m)	
Walks (12m)		2 words (12m	
Climbs stairs (16m)		5-10 words, tower of 3 cubes, fetches (16m)	
Throws Ball		10-25 words, Points to self, scribbles (18m)	
Walks up stairs(20-22)		2 word combination (20-22m)	

Is the child toilet trained? Yes. No. At what age or stage? _____

If the child is in school, what grade? _____ Any learning problems? _____

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Name:_____ Date:_____

SOCIAL HISTORY

What is the child's home environment like? _____

Is the child adopted? ____ What family members live in the home? _____

Is there any smoking in the home? _____ Other environmental exposures? _____

Does the child do sports or exercise? _____ If so, what type? _____

What are the child's hobbies or interests? _____

FAMILY HISTORY

Please list any family illnesses:

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					

REVIEW OF SYSTEMS

Please check any of the following issues if present:

___Weight gain/loss
___Energy change
___Fever/chills
___Rashes
___Skin sores/growths
___Skin color changes
___Head trauma
___Headaches
___Head flattening
___Vision issues
___Red eye(s)
___Eye tearing/discharge
___Lazy eye
___Ear infections
___Hearing trouble

___Balance issues
___Nasal discharge
___Nasal obstruction
___Frequent colds
___Snoring/mouth breather
___Sore throat
___Large tonsils
___Dental issues
___Shortness of breath
___Coughing
___Sputum
___Chest pain
___Palpitations
___Heart murmur
___Congenital heart issue

___High blood pressure
___Blue hands/feet
___Swelling
___Feeding issues
___Suck/swallow issues
___Nausea/Vomiting
___Constipation
___Reflux/Spitting up
___Urinary infections
___Bed wetting
___Urinary reflux
___Paralysis/weakness
___Seizures
___Loss of consciousness
___Tremor

___Numbness/Tingling
___Memory/concentration
___Joint pain/swelling
___Stiffness
___Low muscle tone
___Scoliosis
___Depression
___Anxiety
___Autism Spectrum
___Abuse
___Thryroid problem
___Diabetes
___Anemia
___Bleeding issues
___Swollen lymph nodes

For Physician's use: