

Patient Name \_\_\_\_\_

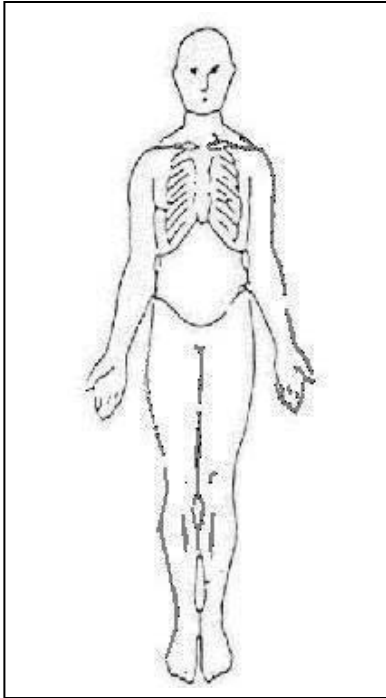
### Medical History

Chief Complaint \_\_\_\_\_  
\_\_\_\_\_

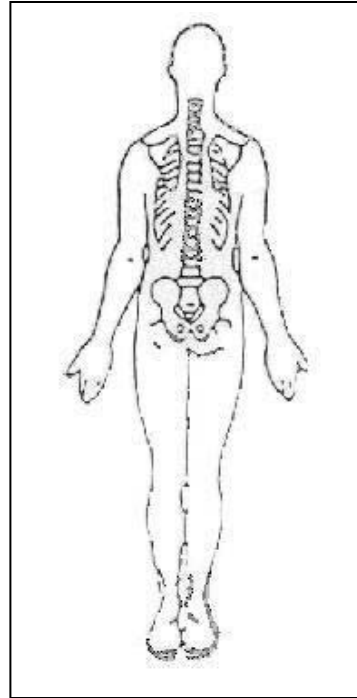
Current Medications \_\_\_\_\_

Allergies to Medications/Other \_\_\_\_\_

Do you have any allergies to latex? \_\_\_\_\_ Exercise (type/how often) \_\_\_\_\_



Anterior: Shade in Regions of Pain



Posterior: Shade in Regions of Pain

### Hospitalizations

Year	Operation/Illness	Hospital	City/State
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First: \_\_\_\_\_

Second: \_\_\_\_\_

### Family Medical History

Please mark any conditions that have been suffered by a blood relative. Also indicate which relative.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Genetic Diseases | <input type="checkbox"/> Blood Clotting Problems |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney/Bladder Problems |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Gout             | <input type="checkbox"/> High Blood Pressure     |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Other _____             |

Patient Name \_\_\_\_\_

## Personal Medical History

Please place a check next to those conditions that you have had in the past and that are no longer present. Circle those conditions that you are currently experiencing. Also indicate your age at the onset of these conditions

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Failing Vision             | <input type="checkbox"/> Diverticulosis               | <input type="checkbox"/> Phobias                     |
| <input type="checkbox"/> Double/Blurred Vision      | <input type="checkbox"/> Hernia                       | <input type="checkbox"/> Mumps                       |
| <input type="checkbox"/> Eye Pain                   | <input type="checkbox"/> Bladder Infections           | <input type="checkbox"/> Measles                     |
| <input type="checkbox"/> Eye Infections             | <input type="checkbox"/> Kidney Infections            | <input type="checkbox"/> German measles              |
| <input type="checkbox"/> Decreased Hearing          | <input type="checkbox"/> Pain on Urination            | <input type="checkbox"/> Chicken Pox                 |
| <input type="checkbox"/> Ringing/Buzzing in Ears    | <input type="checkbox"/> Poor Control of Urination    | <input type="checkbox"/> Polio                       |
| <input type="checkbox"/> Ear Infections             | <input type="checkbox"/> Decreased Force of Urination | <input type="checkbox"/> Gall Bladder Problems       |
| <input type="checkbox"/> Allergies/Hay Fever        | <input type="checkbox"/> Blood in Urine               | <input type="checkbox"/> Jaundice/Hepatitis          |
| <input type="checkbox"/> Sinus Trouble              | <input type="checkbox"/> Kidney Stones                | <input type="checkbox"/> Scarlet Fever               |
| <input type="checkbox"/> Nose Bleeds                | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Rheumatic Fever             |
| <input type="checkbox"/> Frequent Sore Throats      | <input type="checkbox"/> Chronic Fatigue              | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Prolonged Hoarseness       | <input type="checkbox"/> Recent Weight Loss           | <input type="checkbox"/> Malaria                     |
| <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Excessive Weight Gain        | <input type="checkbox"/> Mononucleosis               |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Recreational Drug Use       |
| <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Bruise Easily                | <input type="checkbox"/> Alcohol: _____              |
| <input type="checkbox"/> Chronic Cough              | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Cigarettes _____            |
| <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> Diabetes                     | Packs per Day _____                                  |
| <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Convulsion/Seizures          | <input type="checkbox"/> Coffee _____                |
| <input type="checkbox"/> Short Breath-On Exertion   | <input type="checkbox"/> Stroke                       | Cups per Day _____                                   |
| <input type="checkbox"/> Short Breath-Lying Flat    | <input type="checkbox"/> Tremors                      |  |
| <input type="checkbox"/> Chest Pains                | <input type="checkbox"/> Muscle Weakness              | <input type="checkbox"/> Other Conditions not listed |
| <input type="checkbox"/> Heart Murmurs              | <input type="checkbox"/> Numbness/Tingling Sensation  | above:   |
| <input type="checkbox"/> Palpitations               | <input type="checkbox"/> Frequent Headaches           | _____  |
| <input type="checkbox"/> Swollen Ankles             | <input type="checkbox"/> Migraine Headaches           | _____  |
| <input type="checkbox"/> Fainting Spells            | <input type="checkbox"/> Broken Bones: _____          | _____  |
| <input type="checkbox"/> Leg Pain/Walking           |   |  |
| <input type="checkbox"/> Varicose Veins             | <input type="checkbox"/> Arthritis                    | #Live Births _____                                   |
| <input type="checkbox"/> Recent Loss of Appetite    | <input type="checkbox"/> Osteopenia                   | #Miscarriages _____                                  |
| <input type="checkbox"/> Difficulty Swallowing      | <input type="checkbox"/> Osteoporosis                 | Birth Control Type _____                             |
| <input type="checkbox"/> Heart Burn                 | <input type="checkbox"/> Gout                         | Age/Onset of Menses _____                            |
| <input type="checkbox"/> Persistent Nausea/Vomiting | <input type="checkbox"/> Cold or Numb Feet            | <input type="checkbox"/> Regular Period __Y__N       |
| <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Rashes                       | <input type="checkbox"/> Light Flow                  |
| <input type="checkbox"/> Chronic Abdominal Pain     | <input type="checkbox"/> Psoriasis                    | <input type="checkbox"/> Moderate Flow               |
| <input type="checkbox"/> Recent Change-Bowel Habits | <input type="checkbox"/> Eczema                       | <input type="checkbox"/> Heavy Flow                  |
| <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Hives                        | Length of Flow _____                                 |
| <input type="checkbox"/> Difficulty Sleeping        | <input type="checkbox"/> Nervousness                  | Length of Cycle _____                                |
| <input type="checkbox"/> Constipation               | <input type="checkbox"/> Anxiety Depression           | <input type="checkbox"/> Pain/Bleeding with          |
| <input type="checkbox"/> Black or Tarry Stool       | <input type="checkbox"/> Memory Loss                  | Intercourse __Y__N                                   |
| <input type="checkbox"/> Red Blood in Stool         | <input type="checkbox"/> Moodiness                    | <input type="checkbox"/> PMS (Moderate to Severe)    |
| <input type="checkbox"/> Hemorrhoids                | <input type="checkbox"/> Alcoholism                   |  |

OSTEOPATHIC FAMILY PHYSICIANS, Ltd.  
Stephen Blood, D.O., FAAO, FACOFP, FCA

**PRACTICE POLICIES**

- Emergencies: During non-business hours we will refer you to your local emergency department or primary care physician.
- Cancellations/Missed: **Our doctors do not double book or over book.** Our office has a minimum 24 hour cancellation policy. If this is not possible, please call us as early as possible. Please cancel Monday appointments the previous Friday. Failing to cancel an appointment in advance may result in a normal appointment charge.
- Appointments
- Scheduling: Appointments are scheduled back to back. The doctor does not have the freedom to spend additional time with a patient who arrives late.
- Payment: Payment is requested and expected at the time service is provided. Payment can be made by check, cash or credit card.
- Prescriptions: A fee of \$25.00 will be applied to all prescriptions lost, stolen or newly prescribed without an office visit.
- Returned Checks: A fee of \$25.00 will be applied to each returned check.
- Insurance(s): Dr. Blood does not participate with **ANY** insurance carrier, Worker's Compensation or Medicare. Note to TRICARE beneficiaries, we are a "non-authorized" provider. Our office provides you with a receipt for your use.
- If you are covered by Medicare, TRICARE, or are a retired federal employee, you must notify the front office staff and sign a treatment waiver.  
**MEDICARE PATIENTS CANNOT SUBMIT TO MEDICARE; TRICARE PATIENTS CANNOT SUBMIT TO TRICARE.** If you have a secondary insurance carrier, you may be able to submit to them.
- Patient Initials\_\_\_\_\_ Patient agrees to notify office staff if they become Medicare or TRICARE eligible.
- Authorization: I hereby authorize Stephen Blood, D.O. to release to my insurance carrier any information needed to process my insurance claim. I understand that payment for services rendered is due and payable by me regardless of insurance coverage. I also agree to pay for the cost of collections should my account become delinquent (including reasonable attorney fees).
- Consent: Due to health risks involved with accidental needle sticks, in the event of an accidental needle stick incurred by any personnel, I hereby give my permission to have my blood drawn for testing, at no additional cost.
- Privacy Policy My signature below acknowledges that I have been informed of the Patient Privacy Policy for Osteopathic Family Physicians. I may request a copy of this policy at any time and it will be provided to me.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

OSTEOPATHIC FAMILY PHYSICIANS, Ltd.  
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**New Patient Registration Sheet**

Name \_\_\_\_\_ Date \_\_\_\_\_  
First, Last, Middle Initial

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Work Telephone ( ) \_\_\_\_\_

Marital Status: S M D W Sex: Male Female

Social Security# \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Referral Source \_\_\_\_\_

Insurance company\* (name only) \_\_\_\_\_

\*\*\*Please Note\*\*\*

\*If you are covered by Medicare, TRICARE, or retired from the federal government, you must inform our front office staff and be prepared to sign a waiver.\*