

PEINE

OSTEOPATHIC
MEDICINE

Dear New Patient -

Thank you for downloading and printing these forms. My hope is that your first visit will be more efficient and productive as a result. You can change or cancel your appointment any time using the online scheduling service on my website. Simply log on using your email address and password.

Please bring the following items with you to your first appointment:

- Completed registration forms
- Authorization from your primary care provider, if required by your insurance
- Check or cash for office copay – please note Dr. Peine does not accept debit or credit cards

NOTE: Because I have become so busy, I recommend making 2 additional “returning patient” visits after your initial “new patient” visit. This way, I can ensure that you receive proper follow-up care in a timely manner. Otherwise, it may be difficult to obtain another appointment for several weeks after your initial visit!

Feel free to contact me via phone (208) 947-0925 or email me at drpeine@drpeine.com if you have any questions or problems.

Sincerely,

Chris Peine, D.O.



NEW PATIENT INFORMATION

Patient Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ Date of Birth: _____ Age: _____

Email Address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

I was referred to Dr. Peine by _____

Responsible Party Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ Date of Birth: _____ Phone: _____

Relationship to Patient: _____

Emergency Contact Name: _____ Phone: _____

INSURANCE INFORMATION

Is this a work comp injury? Yes No If yes, insurance claim No: _____

Name of Work Comp Insurance: _____

Primary Insurance Co: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name of Insured: _____ Relationship to Patient: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance Co: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relationship to Patient: _____

Subscriber ID: _____ Group Number: _____



CONSENT TO TREATMENT

I hereby consent to such treatment/procedures as may be rendered by Dr. Peine. I authorize the release of any information necessary to process my claim and the direct payment of benefits to Peine Osteopathic Medicine. I understand that I may be charged for late appointments, and that I am financially responsible for all services rendered. I understand that Dr. Peine is not my primary care physician and that I will contact my primary care physician or dial 911 in the event of an emergency.

Patient Signature _____
(parent if patient is a minor)

Printed Name: _____ Date: _____

PROVIDER NOTICE OF PRIVACY PRACTICES

In accordance with federal law, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods. We may use or disclose identifiable health information about you with your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

Patient Rights: You can also request a copy of our notice at any time. For more information about our privacy practices, contact Peine Osteopathic Medicine PLLC. **Complaints:** If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Peine Osteopathic Medicine, PLLC. You may also send a written complaint to the U.S. Department of Health and Human Services.

I Acknowledge I have read and understand the above Notice of Privacy Practices:

Patient Signature: _____
(parent if patient is a minor)

Printed Name: _____ Date: _____



NEW PATIENT HISTORY

Patient Name: _____ Date: _____

Primary reason I need to be seen by Dr. Peine (please be concise):

In the chart below, please list all current medical problems (high blood pressure, depression, etc.) as well as major problems you have had in the past:

Year	Diagnosis, injury, or Hospitalization	Year	Diagnosis, injury, or hospitalization

In the chart below, please list all surgical procedures you have undergone:

Year	Surgical Procedure	Year	Surgical Procedure

In the chart below, please list all medications you are currently taking:

Medication	Dose/frequency	Medication	Dose/frequency

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Please list any medications you are allergic to:

Please circle any of the following symptoms or diseases that apply to you currently or in the past:

Hearing loss	Loss of appetite	Easy bruising	Slipped disc
Ringing in ears	Weight loss	Cancer	Sciatica
Ear Infections	Night sweats	Diabetes	Carpal tunnel syndrome
Dizziness	Hot flashes	Seizures	Psoriasis
Blurry or double vision	Nausea or vomiting	Stroke	Gout
Sinus trouble	Heartburn	Numbness or tingling	Anxiety
Allergies	Gall bladder trouble	Thyroid disease	Depression
Pneumonia	Jaundice	Chronic fatigue	Mental Illness
Cough	Diarrhea	Tremor or hand shaking	Difficulty sleeping
Asthma or wheezing	Constipation	Arthritis	Difficulty concentrating
Shortness of breath	Abdominal pain	Osteoporosis	Tension headaches
Chest pain	Bloody or black stools	Broken bones	Migraine Headaches
High blood pressure	Hemorrhoids	Tailbone injuries	Menstrual cramps
Swollen ankles	Incontinence of urine or stool	Concussion	Pelvic pain
Palpitations	Pain with urination	Car accident	Menopause
Fainting spells	Difficulty urinating	Joint pain	Pregnancy
Leg pain when walking	Blood in urine	Rotator cuff problems	Difficult childbirth
Varicose veins	Prostate problems	Neck pain	Low energy
Swollen calf	Kidney stones	Whiplash	Chronic stress
Blood clots	Anemia	Back pain	



Other important information:

Complimentary or alternative therapies I am currently using (chiropractic, acupuncture, nutritional supplements, etc):

Please honestly answer the following:

I have smoked about _____ packs of cigarettes per day for _____ years and I quit _____ years ago.

I drink _____ caffeinated beverages each day.

I drink _____ alcoholic beverages each day.

I sleep about _____ hours per night.

I exercise _____ hours per day _____ times per week.

My stress level is (please mark):

very high high low higher than normal less than normal