**Falls Church Osteopathic Medicine**
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Falls Church Osteopathic Medicine
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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.*

# Medical History

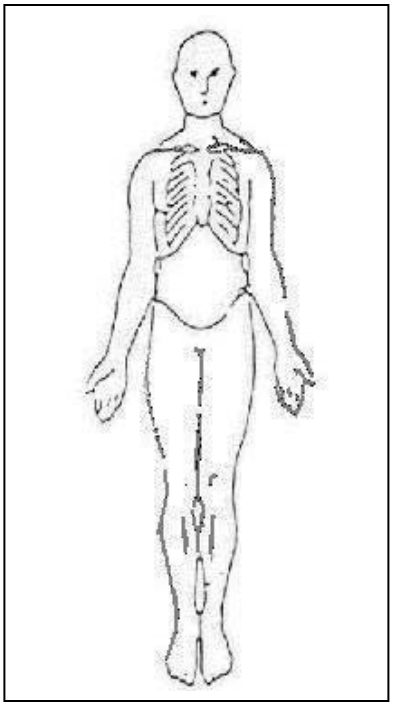
Chief Complaint_____

_____

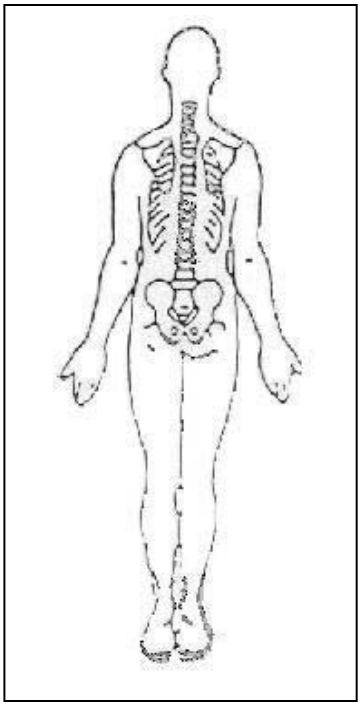
Current Medications_____

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 |
|---|---|---|---|

First: _____

Second: _____

## Family Medical History

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

| | | |
|---|---|---|
| ( ) Allergies | ( ) Genetic Diseases | ( ) Blood Clotting Problems |
| ( ) Cancer | ( ) Ulcers | ( ) Arthritis |
| ( ) Glaucoma | ( ) Heart Disease | ( ) Epilepsy |
| ( ) Stroke | ( ) Anemia | ( ) Headaches |
| ( ) Mental Illness | ( ) Diabetes | ( ) Kidney/Bladder Problems |
| ( ) Asthma | ( ) Gout | ( ) High Blood Pressure |
| ( ) Alcoholism | ( ) Tuberculosis | ( ) Other _____ |

# 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

( ) Failing Vision
( ) Double/Blurred Vision
( ) Eye Pain
( ) Eye Infections
( ) Decreased Hearing
( ) Ringing/Buzzing in Ears
( ) Ear Infections
( ) Allergies/Hay Fever
( ) Sinus Trouble
( ) Nose Bleeds
( ) Frequent Sore Throats
( ) Prolonged Hoarseness
( ) Thyroid Disease
( ) Asthma
( ) Emphysema
( ) Chronic Cough
( ) Bronchitis
( ) Pneumonia
( ) Short Breath/Exertion
( ) Short Breath/Lying Flat
( ) Chest Pains
( ) Heart Murmurs
( ) Palpitations
( ) Swollen Ankles
( ) Fainting Spells
( ) Leg Pain/Walking
( ) Varicose Veins
( ) Recent Loss of Appetite
( ) Difficulty Swallowing
( ) Heart Burn
( ) Persistent Nausea/Vomiting
( ) Ulcers
( ) Chronic Abdominal Pain
( ) Recent Change/Bowel Habits
( ) Diarrhea
( ) Difficulty Sleeping
( ) Constipation
( ) Black or Tarry Stool
( ) Red Blood in Stool
( ) Hemorrhoids
( ) Diverticulosis

( ) Hernia
( ) Bladder Infections
( ) Kidney Infections
( ) Pain on Urination
( ) Poor Control of Urination
( ) Decreased Force of Urination
( ) Blood in Urine
( ) Kidney Stones
( ) Sexually Transmitted Disease
( ) Chronic Fatigue
( ) Recent Weight Loss
( ) Excessive Weight Gain
( ) Anemia
( ) Bruise Easily
( ) Cancer
( ) Diabetes
( ) Convulsion/Seizures
( ) Stroke
( ) Tremors
( ) Muscle Weakness
( ) Numbness/Tingling Sensation
( ) Frequent Headaches
( ) Migraine Headaches
( ) Broken Bones: _____
_____
( ) Arthritis
( ) Osteopenia
( ) Osteoporosis
( ) Gout
( ) Cold or Numb Feet
( ) Rashes
( ) Psoriasis
( ) Eczema
( ) Hives
( ) Nervousness
( ) Anxiety Depression
( ) Memory Loss
( ) Moodiness
( ) Alcoholism
( ) Phobias
( ) Mumps

( ) Measles
( ) German measles
( ) Chicken Pox
( ) Polio
( ) Gall Bladder Problems
( ) Jaundice/Hepatitis
( ) Scarlet Fever
( ) Rheumatic Fever
( ) Tuberculosis
( ) Malaria
( ) Mononucleosis
( ) Recreational Drug Use
( ) Alcohol: _____
( ) Cigarettes _____
Packs per Day _____
( ) Coffee_____
Cups per Day_____

( ) Other Conditions not listed above:
_____
_____
_____

#Live Births_____
#Miscarriages_____
Birth Control Type_____
Age/Onset of Menses____
( ) Regular Period__Y__N
( ) Light Flow
( ) Moderate Flow
( ) Heavy Flow
Length of Flow_____
Length of Cycle_____
( ) Pain/Bleeding with Intercourse___Y___N
( ) PMS (Moderate to Severe)

# Practice Policies

Emergencies: During non-business hours we will refer you to your local Emergency department or primary care physician.

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Cancellations/Missed Appointments:

**Dr. Craddock does 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 charge for the missed appointment.

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.

Returned Checks: A fee of $45.00 will be applied to each returned check.

Insurance(s): Dr. Craddock does not participate with any insurance carrier, Workers' Compensation or Medicare. Our office will provide you with a statement that you can submit to your carrier for reimbursement. Note to TRICARE beneficiaries, we are a "non-authorized" provider.

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, however, if you have a secondary insurance carrier, you may submit to them.

Authorization: I hereby authorize Falls Church Osteopathic Medicine, LLC and/or Gregory Craddock, 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 herby give my permission to have my blood drawn for testing, at no cost to the patient.

Privacy Policy My signature below acknowledges that I have received a copy of and read the Patient Privacy Advisory of Falls Church Osteopathic Medicine, LLC, (Privacy Policy is previous two pages)

_____ _____

Print Name Date

_____

Signature