PEINE
OSTEOPATHIC
MEDICINE

Dear Patient,

Thank you for taking the time to fill out the following new patient forms before your first visit. Please mail, fax or drop off your new patient paperwork to the office prior to your initial appointment. This will allow our time together to be more efficient and productive.

Please bring the following with you to your initial appointment:

- A copy of any blood (lab) work that has been done in the past year, as well as any reports from any relevant past imaging studies (x-rays, MRI, CT scans, etc). It is not necessary for you to bring copies of your films to your initial visit. Your doctor's office may fax this information directly to us. Fax: (208) 947-0926.

- Your insurance card, or a copy of the front and back of your insurance card.

- Credit card, check, or cash for your insurance copayment, coinsurance or deductible.

Please be punctual so as to benefit fully from your appointment. **There will be a $100 no-show fee assessed if cancellation is not made at least 24 hours prior to your appointment.**

Our office will bill your insurance. However, please be advised the services we provide may not be covered. If this is the case, discounted rates and other payment arrangements are available. For billing and other questions, you may contact Jessica Whitney, practice manager, at jwhitney@drpeine.com.

Our office address is 507 S Fitness Place, Suite 110 Eagle, ID 83616. We are located off of Old State Street and Plaza Drive approximately .5 miles east of the intersection of Eagle Road and "old" State Street (NOT Highway 44, which bypasses downtown Eagle). Turn left onto Iron Eagle Road then immediately right on Fitness Avenue into a cul-de-sac. Our office is in the free-standing building straight ahead.

Please feel free to contact us at 208/947.0925 if you have any questions or concerns.

Sincerely,

Chris Peine, DO
Peter Abraham, DO

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NEW PATIENT INFORMATION

Last Name:_____ **First Name**:_____ **Middle Initial**:____

Gender: M / F **SSN**:_____ **Marital Status**: Married Single Divorced Widowed Separated

Date of Birth:_____ **Age**:_____

Race (please circle): American Indian or Alaska Native Asian Black or African American

Native Hawaiian or other Pacific Island Hispanic Caucasian Other Decline to Answer

Ethnic Group (please specify, for example: Argentinean, Chilean, etc):_____

Primary Language (please circle):Arabic Chinese English French German Japanese Russian Spanish Vietnamese Other

Address:_____City:_____ State:_____ ZIP:_____

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

Responsible Party Name (if patient is a minor):_____

Relationship to Patient:_____**Phone**:_____

Emergency Contact Name:_____ **Phone**:_____

Do you have an Advanced Medical Directive and / or Living Will and Durable Power of Attorney? ___ Yes ___ No

Preferred Message / Contact Phone (please circle): Phone Secure Email Patient Portal

Preferred Reminder Method (please circle): Mobile Phone Home Phone Email Patient Portal

Email Address:_____ **I was referred by**:_____

Primary Care Physician: _____ **Phone**:_____ **Fax**:_____

Names of any specialists you see (please provide phone and fax numbers if available): _____

_____

_____

_____

_____

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INSURANCE INFORMATION

NOTE: Our office policy is that we do not bill for motor vehicle related accidents. We will be happy to see you as a self-pay patient until settlement is made between you and the insurance company. We will gladly refund you what you have paid out of pocket once we receive payment from your insurance company.

Is this visit related to an injury of any kind? □Yes □No If yes, what is the initial date of injury? _____

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

Name of Work Comp Carrier and Billing Information:_____

Is this a motor vehicle accident related injury? □Yes □No

Primary Insurance Co:_____

Policy Holder:_____ Relationship to Patient:_____ Date of Birth: _____

Secondary Insurance Co:_____

Policy Holder:_____ Relationship to Patient:_____ Date of Birth: _____

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

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. I assume all financial responsibility for the balance of charges not included in the insurance coverage. 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.

Signature_____
(parent if patient is a minor)

Printed Name:_____Date:_____

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PATIENT PORTAL AUTHORIZATION FORM

Patient Name: _____

Responsible Party Name: _____

Personal Email Address: _____
(Please supply the personal email address of the person who will be using the patient portal)

Purpose of this Form:
The patient portal offers patients of Peine Osteopathic Medicine a secure way to view parts of their records and communicate with our staff. Secure messaging is a valuable communication tool for our practice, but it has certain limitations and guidelines. Please read this form thoroughly before signing.

How the Patient Portal Works:
A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those for whom you are legally responsible.

Via the Patient Portal you will be able to: ❖ Use the message function to communicate with our staff ❖ Schedule, confirm, cancel or reschedule an appointment ❖ Communicate about billing questions❖ Request a referral or medication refill ❖ View health summary information in your electronic chart and send staff requests to update information ❖ View demographic / insurance information and send staff requests to update information❖ Print or save an electronic copy of the health summary using the continuity of care record (CCR) format.

How to Participate in the Patient Portal:
Once this form is agreed to and signed, you will receive a user name and password via your personal email account. There is a link to the patient portal on our website, www.peineosteopathic.com. You will be able to log in using the username and password provided.

Protecting Your Private Health Information and Risks:
This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you MUST inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal.

Conditions of Participating in the Patient Portal:
We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service and we may suspend or terminate it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the patient portal and by signing this form you agree to:

1) Not transmit any electronic information that violates the rights or privacy of any party.
2) Use the web portal in any way that would violate local, state or federal laws.
3) Not transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others.
4) Intentionally distribute viruses code or take any other action that could compromise the security of our computer system.

Patient / Guardian Acknowledgement:

Signature: _____ Date: _____

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INFORMED CONSENT REGARDING NUTRITIONAL SUPPLEMENT AND FUNCTIONAL MEDICINE LABORATORY TESTING

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

My signature acknowledges I have read and understand the above.

Signature**:**_____ Date:_____

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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**:_____

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVES

I, _____, give my authorization to release my protected health information, including results of my laboratory tests, x-ray, CT, and / or other relative information to the following designated representative(s):

Patient Initials	**Designated Representatives**
_____	Spouse_____
_____	Children_____
_____	_____
_____	_____
_____	Other_____
_____	May be left on my answering machine at home.
_____	May be left on my mobile phone voice mail.
_____	May not be given to anyone other than myself.

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

Printed Name:_____**Date:**_____

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MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these written questions. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us?

_____

_____

_____

_____

When was the last time you felt healthy?

_____

_____

_____

_____

Did something trigger your change in health?

_____

_____

_____

_____

What makes you feel worse?

_____

_____

What makes you feel better?

_____

_____

Your current age: _____

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ALLERGIES □None
Please list any allergies to medications, supplements, or foods. Environmental allergies such as dust, pollen, etc. are unnecessary.

Medication/Food/Supplement	Reaction

MEDICATIONS □None
Please include non-prescription medications.

Medication Name	Date Started	Dosage/Frequency Taken

NUTRITIONAL SUPPLEMENTS □None
List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

Supplement Name	Date Started	Dosage/Frequency Taken

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MEDICAL HISTORY

Please carefully review the following list and indicate any conditions that apply to you: in the **past** (mark with a **P**) or if it is an issue for you **currently** (mark with a **C**). Please record any other pertinent information in the comments section, and feel free to attach any documents, lab results, notes, etc. that are relevant.

Disease/Condition	Past(P) / Current(C)	Dates/Details
Gastrointestinal		
Crohn's Disease or Ulcerative Colitis		
Gallstones		
Irritable Bowel Syndrome		
Ulcers		
Reflux/Hearburn		
Celiac Disease		
Food Sensitivities (please list)		
Chronic Constipation		
Other		
Cardiovascular		
Heart Attack/Angina		
Congestive Heart Failure		
Stroke		
Arrhythmia/Irregular Heart Beat		
High Cholesterol/Triglycerides		
High Blood Pressure (Hypertension)		
Heart Valve Disease/Rheumatic Fever		
Blood Clots		
Other		
Metabolic/Endocrine		
Diabetes (specify borderline, type 1 or type 2)		
Low or High Thyroid		
Low Blood Sugars (Hypoglycemia)		
Polycystic Ovary Syndrome (PCOS)		
Infertility		
Unexplained Weight Gain		
Unexplained Weigh Loss		
Eating Disorder (please specify type)		
Other		

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Disease/Condition	Past(P) / Current(C)	Dates/Details
Cancer - Please enter type(s) below:		
Type:		
Type:		
Genital/Urinary		
Kidney Stones		
Recurrent Urinary Tract Infections (UTI)		
Recurrent Yeast Infections		
Gout		
Enlarged Prostate		
Sexual or Erectile Dysfunction		
Renal Failure		
Endometriosis/Menstrual Problems		
Other		
Musculoskeletal/Pain		
Osteoarthritis		
Chronic Pain - Please specify area		
Spinal Disc Degeneration		
Fracture – Please specify bone		
Thinning of the Bones (Osteoporosis/-penia)		
Shoulder Injury		
Knee Injury		
Other Joint Injury		
Carpal Tunnel Syndrome		
Other		
Inflammation/Autoimmune		
Fibromyalgia		
Rheumatoid Arthritis		
Chronic Fatigue Syndrome		
Lupus		
Immune Deficiency Disease (HIV)		
Frequent Infections – Please describe		
Environmental Allergies		
Food Allergies		
Chemical Sensitivities		
Other		

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Disease/Condition	Past(P) / Current(C)	Dates/Details
Respiratory/Pulmonary		
Asthma		
Emphysema		
Chronic/Recurrent Sinusitis		
Chronic/Recurrent Bronchitis		
Sleep Apnea		
Pneumonia		
Other		
Skin Diseases		
Eczema		
Psoriasis		
Acne		
Skin Cancer – Please specify type		
Other		
Neurological		
Autism		
Tension Headaches		
Migraine Headaches		
Parkinson's Disease		
Multiple Sclerosis		
Seizure Disorder		
Dementia/Alzheimer's Disease		
Stroke/Transient Ischemic Attack		
Peripheral Neuropathy		
Other		
Injuries		
Back Injury – Please describe		
Neck Injury – Please describe		
Head Injury – Please describe		
Other		
Other		
Other		
Hematologic		
Anemia		
Other		

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SURGERIES/MEDICAL PROCEDURES ☐**None**

Please list the dates and types of surgery or medical procedures you have undergone.

Date	Type of Surgery or Medical Procedure

FAMILY HISTORY

Please indicate family members with any of the following conditions. Please specify your relationship using the following key: mother(M), father(F), brother(B), sister(S), paternal grandfather(PGF), paternal grandmother(PGM), maternal grandfather(MGF), maternal grandmother(MGM), paternal uncle(PU), paternal aunt(PA), maternal uncle(MU), maternal aunt(MA), cousin (C).

Condition	Relationship	Notes
Alcoholism		
Anxiety		
Asthma		
Enlarged Prostate		
Breast Cancer		
Stroke		
Colon Cancer		
Coronary Artery Disease		
Depression		
Diabetes, Type 2		
High Cholesterol		
High Blood Pressure		
Low Thyroid		
Heart Attack		
Osteoarthritis		
Ovarian Cancer		
Prostate Cancer		
Other		
Other		
Other		

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PSYCHOSOCIAL/STRESS HISTORY

Occupation:_____
Marital Status: □Single □Married □Divorced □Gay/Lesbian □Long Term Partnership □Widowed
Number of Children: _____
Who lives in your household? _____

Hobbies and Leisure Activities:_____

Do you drink alcohol? ☐Yes ☐No
If yes, how often do you drink alcohol? _____# of drinks per week
Have you ever had a problem with drugs or alcohol? ☐Yes ☐No
If yes, please indicate time period (month/year): from _____ to _____

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No
If yes, number of years as a nicotine user: _____ Amount per day: _____ Year quit: _____
What type of nicotine have you used? ☐Cigarette ☐Smokeless ☐Cigar ☐Pipe ☐Patch/Gum
Are you exposed to secondhand smoke regularly? ☐Yes ☐No

Do you have trouble sleeping? ☐Yes ☐No
Do you have trouble falling asleep? ☐Yes ☐No
Do you require medication or alcohol to fall asleep? ☐Yes ☐No
Do you have trouble staying asleep? ☐ Yes ☐No Estimated number of awakenings per night:_____

Are you sensitive to bright lights, loud noises, strong odors? ☐ Yes ☐ No
Do you feel overwhelmed easily? ☐ Yes ☐ No
Do you feel worse at certain times of the year? ☐ Yes ☐ No
If yes, when? ☐Spring ☐Fall ☐Summer ☐Winter

Do you feel significantly less vital than you did a year ago? □Yes □No
Are you happy? □Yes □No
Do you believe stress is presently reducing the quality of your life? □Yes □No
Do you feel you have an excessive amount of stress in your life? □Yes □No

What are the sources of your stress?_____

_____

How do you deal with your stress?_____

_____

_____

Have you ever been abused, a victim of crime, or experienced a significant trauma? □Yes □No

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No
☐Currently ☐Previously If previously, from _____ to _____

Comments: _____

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MENTAL HEALTH HISTORY

Please Indicate if you suffer from or have been diagnosed with any of the following:

Condition	Past(P) / Current(C)	Dates/Details
Feeling depressed		
Diagnosed with Depression		
Mania/Bipolar Disorder		
Feeling anxious		
Diagnosed with Generalized Anxiety Disorder		
Insomnia		
Attention Deficit Disorder (ADD)		
Attention Deficit/Hyperactivity Disorder (ADHD)		
Obsessive-Compulsive Disorder		
Personality Disorder – Please specify		
Schizophrenia		
Other – Please specify		

Have you ever been hospitalized for any of the above? ☐ Yes ☐ No

COMMENTS/OTHER IMPORTANT INFORMATION:

_____

_____

_____

_____

_____

_____