

Missoula Osteopathic Clinic, PLLC
341 W Pine St. Missoula, Montana. 59802
(406) 327-0269, (406) 327-0264 Fax

**Acknowledgement of Receipt of
Notice of Privacy Practices**

By signing this form, you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice.

If you have not already, please review the Notice of Privacy Practices:

Online, Adobe Acrobat Format (PDF)

<http://www.missoulaosteopathic.com/downloads/hippamoc.pdf>

Online, Microsoft Word Format (DOC)

<http://www.missoulaosteopathic.com/downloads/hippamoc.doc>

Or **call 406-327-0269** to request a copy

I have received a copy of the Notice of Privacy Practices. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

Patient's Signature or Guardian

Date Signed

Provider Use Only

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _____ Yes _____ No

Reason signature was not obtained _____

Staff Signature

Date

Missoula Osteopathic Clinic, PLLC
341 W Pine St. Missoula, Montana. 59802
(406) 327-0269, (406) 327-0264 Fax

Cancellation Policy

Please read carefully and sign

Due to an increase in patient demand we can no longer allow less than a 24-hour notice to cancel an appointment. We are trying to accommodate everyone and apologize for any inconvenience this may cause. If you do not give 24 hours notice you will be charged \$75.00 for the missed appointment. You are responsible for this; your insurance company will not pay this fee.

If unforeseen circumstances arise and you are able to give notice that is less than 24 hours we will do our best to fill the vacancy. If we are able to do so, you will not be charged. The more notice you can give the better able we are to accommodate other patients who may be on a waiting list.

Thank You

I agree to Missoula Osteopathic Clinic PLCC Cancellation Policy

Please Print Name

Signature

Date

Missoula Osteopathic Clinic, PLLC
341 W Pine St. Missoula, Montana. 59802
(406) 327-0269, (406) 327-0264 Fax

Intake Information

Date _____
Name _____ Date of Birth _____
Last First Middle

Age _____ Occupation _____

Address _____

Day Phone _____ Evening Phone _____

Social Security # _____

Health Insurance Company _____

Secondary Health Insurance _____

Primary Policy Holder _____
Last First Middle

Policy Number _____

Primary Policy Holder Date of Birth _____

Emergency Contact _____ Relation _____

Phone _____

Are you being seen for work related complaint? _____Y _____N

If yes, Date of Injury/Accident _____

Insured Patients Please read and Sign.

I hereby assign my right and authorize and direct my insurance company, or any other liable insurance company, or any other concerned party, including but not limited to Medicare, to make payment directly to Missoula Osteopathic Clinic, PLLC and/or Sam Wallace D.O.

This assignment and direct payment authorization shall include any payments for Doctor Wallace's services rendered at Missoula Osteopathic Clinic, PLLC.

I understand that I am responsible for any amount billed that my insurance company does not cover.

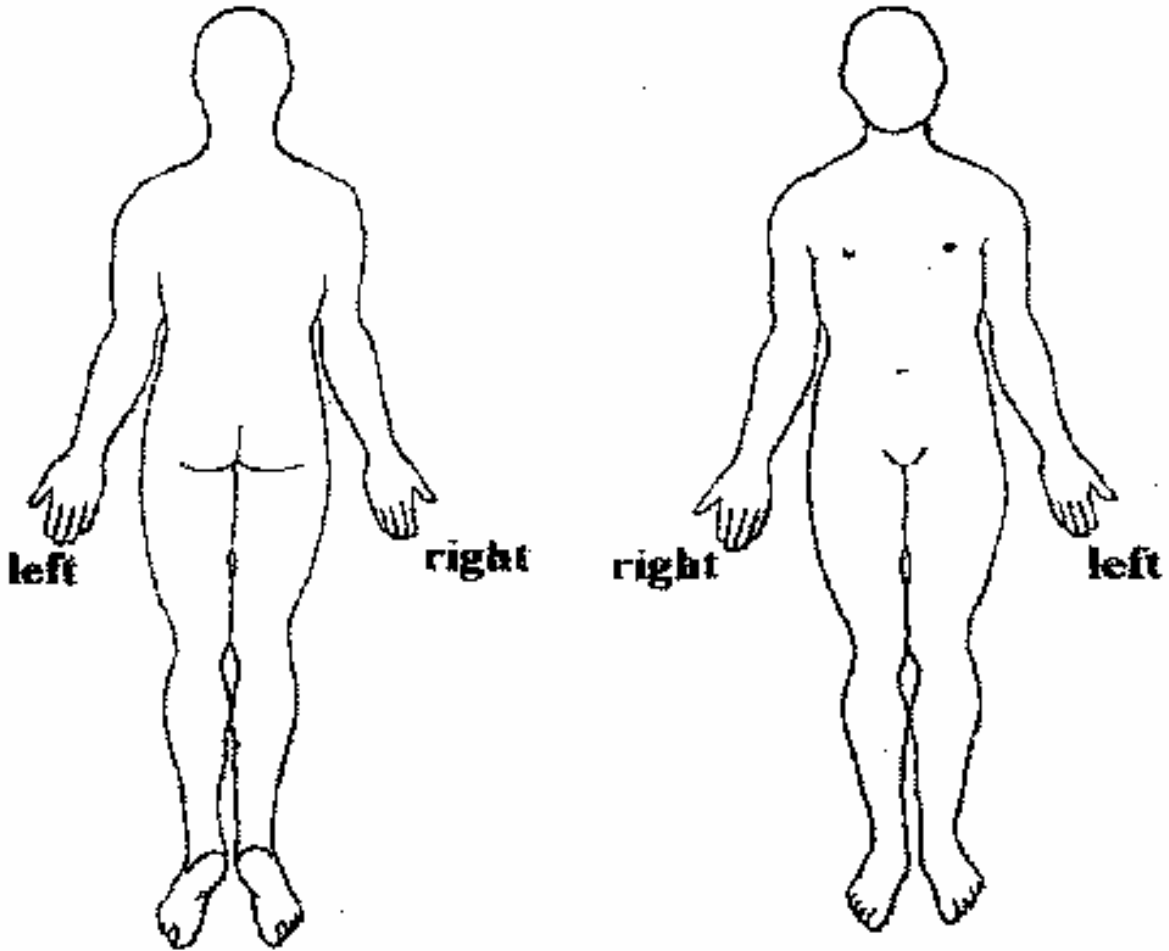
Authorization Signature _____

Pain Diagram

Name _____ Date _____

Draw the location of your pain on the body outlines below. Use the appropriate colored pencil (or letter code) to denote the kind of pain you are having now. Using a pen, draw all scars that are on your body.

<u>ACHE</u>	<u>BURNING</u>	<u>NUMBNESS</u>	<u>PINS & NEEDLES</u>	<u>STABBING</u>	<u>OTHER</u>	<u>SCARS(++)</u>
Brown	Red	Blue	Orange	Green	Yellow	Pen (ink)
Or A	B	N	P	S	O	



No pain (-----) Worse possible pain

Please mark on the pain line what you feel your average pain is.

Missoula Osteopathic Clinic, PLLC
341 W Pine St. Missoula, Montana. 59802
(406) 327-0269, (406) 327-0264 Fax

Patient History - 1

			Date _____
Name _____		DOB _____	
Address _____		Day Phone _____	
Street _____			Eve. Phone _____
_____	_____	_____	
City	State	Zip	

Problem List (symptoms or complaints)	Date Began
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Tests For Above (XRays, MRIs, CAT scans, Blood Test or other)

Date	Facility	Result
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical Problems and Hospitalizations

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Patient History - 2

Medications Currently Used

Name	Date Began	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgeries

Date	Reason	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies

Name	Reaction
_____	_____
_____	_____
_____	_____

Birthplace _____ Residence past 5 years _____

List all states lived in _____

Occupation _____ For how long _____

Married Single Divorced Separated Widowed

Highest Level of Education Completed? Grade School High School College
Masters Doctorate Professional

Alcohol Use (Drinks per day) _____ Type of Alcohol _____

Size of typical drink in ounces _____ Problems with Alcohol NO YES UNSURE

Patient History - 3

Tobacco Use YES NO

Type Used _____ Amount per day _____ Years _____

Caffeinated Beverages YES NO

Type Used _____ Amount per day _____ Years _____

Water Intake _____ Amount per day _____

Pain Reliever Use YES NO

Type Used _____ Amount per day _____ Years _____

Illicit Drug Use YES NO

Type Used _____ Amount per day _____ Years _____

Family History

Father _____ Living _____ Deceased Age _____

-Grandfather _____ Living _____ Deceased Age _____

-Grandmother _____ Living _____ Deceased Age _____

Mother _____ Living _____ Deceased Age _____

-Grandfather _____ Living _____ Deceased Age _____

-Grandmother _____ Living _____ Deceased Age _____

Illnesses

Date of Last: Full Physical Exam _____ Blood Test _____

General

Fever Chills Sweats Weight Loss Weight Gain Night Sweats Fatigue

Skin

Dryness Itching Rashes Acne Growths Bruising

Nails

Ridging Brittle Discolored

Lymph Nodes

Swollen Glands Painful

Endocrine

Change in Appetite Sensitive to heat or cold Extreme Thirst Increased Urination

Head

Headaches, Migraine, trauma, dizziness, fainting, seizures

Eyes

Blurring Glasses Contacts Surgery Cataracts Pain

Patient History - 4

Ears

Deafness tinnitus spinning sensations drainage pain

Nose

Sinus infections congestion bleeding blockage use of over-the-counter nasal sprays

Mouth

Canker sores, gum bleeding, toothaches, mercury fillings, pulled teeth, braces, retainers

Other dental procedures_____

Throat

Soreness loss of voice change in voice

Neck

Swelling swollen glands stiffness

Breasts

Lumps, pain, nipple discharge, Date of last mammogram_____result_____

Respiratory

Difficulty breathing: with exercise at night when lying down

Wheezing, cough, mucus, blood, painful breathing, tuberculosis exposure, pneumonia, asthma, emphysema

Cardiovascular

Chest pain or tightness, skipped heartbeats, swelling in feet or belly, cold feet

Pain in legs when walking helped by resting, blue toes or fingers, high blood pressure, history of rheumatic fever, heart murmurs

Gastrointestinal

Painful swallowing, difficulty swallowing, nausea, vomiting,
bloody or coffee ground appearing vomit, pain in abdomen, jaundice, diarrhea, constipation,
bloody stools, tarry stools, hemorrhoids, rectal pain, hernia

Genitourinary

Frequent urination, absent urination, painful urination, bloody urine, pus in urine

Incontinence of urine, frequent urination at night

Pain in sides, kidney stones, history of bladder or kidney infection.

Women Only: Age at start of periods_____

Age of end of periods_____

If still having periods: Are they regular_____

How long are your cycles_____

Date of last Pap Smear_____ Results_____

Number of pregnancies_____ Dates_____

Births_____ Episiotomies_____

Neurological

Weakness, paralysis, numbness, shakes, seizures, tingling

Mental Status

Mood swings, depression, difficulty sleeping, sleeping too much, delusions, hallucinations