134 Rumford Avenue
Suite 208
Newton, MA 02466
Tel: (617) 431-4451
Fax: (617) 431-4456

Dear New Patient,

Thank you for choosing to make your first visit with us at Boston Osteopathic Health. We are looking forward to meeting you.

Enclosed find your new patient packet, which contains the most accurate directions to our office (back of this page), registration information, information disclosure consent, insurance information, and your initial office visit form. Please complete the relevant portions as accurately as possible and bring them along for your appointment. Also, fill out all high-lighted portions of the initial office visit form on page 1 and 2. **Lastly please plan to arrive 20 minutes early for your appointment time for registration process!**

Please feel free to contact our office with any questions or concerns about your upcoming visit. We are pleased to be a new part of your personal healthcare experience.

Best Regards,

The Staff at Boston Osteopathic Health

BOSTON OSTEOPATHIC HEALTH
134 RUMFORD AVE, SUITE#208
NEWTON, MA 02466

*****Please use these instead of internet directions. These are more accurate*****
*****HANDICAPPED PARKING AVAILABLE IN GARAGE UNDER BUILDING*****

Directions coming from the South:
Take Interstate 95N/MA-128North
Merge onto MA-30 (Commonwealth Ave) via exit 24
toward NEWTON/BOSTON 1.7 mi
Turn Left onto LEXINGTON STREET 0.8 mi
Turn Left onto RUMFORD AVE. 0.1 mi
***Turn Right into first drive (PACARD COVE OFFICE PARK).
134 Rumford Ave is the building set behind straight ahead across parking lot.
Our office is on the second floor, Suite #208***

Directions coming from the North:
Take interstate I-95S/MA-128 South toward LOWELL/WALTHAM
Merge onto MA-30(Commonwealth Ave) East via EXIT 24 toward NEWTON/BOSTON 1.1mi
Turn LEFT on LEXINGTON STREET 0.8mi
Turn Left onto RUMFORD AVE. 0.1mi
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Directions coming from the East/Boston:
Take I-90 West/MASS PIKE/MASSACHUSETTS
Take RT 16 East, EXIT 16, toward WEST NEWTON 0.4mi
Turn SLIGHT RIGHT onto WASHINGTON ST/MA-16 East 0.3mi
Continue following WASHINGTON ST, takes you in circle over MASS PIKE
Stay straight to go onto ELM STREET 0.3mi
TAKE 3RD Left on RIVER STREET 0.6mi
River STREET becomes RUMFORD AVE. 0.1mi
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Directions coming from the West:
Take I-90 East/MASS PIKE/MASSACHUSETTS
Take I-95 North-30/Route-128 North exit, EXIT 14, toward N.H.-MAINE/POINTS NORTH 1.2mi
Merge onto MA-30 via EXIT 24 toward NEWTON/BOSTON 1.0mi
Turn LEFT onto LEXINGTON STREET 0.8mi
Turn LEFT onto RUMFORD AVE. 0.1mi
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PATIENT REGISTRATION

Boston Osteopathic Health

134 Rumford Ave, Suite 208
Newton, MA 02466
Tel. 617-431-4451 Fax. 617-431-4456

TODAY'S DATE _____/_____/_____

Personal Information

Last Name _____ Birthdate _____/_____/_____ Age_____

First Name _____ Social Security # _____

Middle Name _____ Occupation _____

Home Address _____ Employer Name _____

City/State/Zip _____ Employer Address _____

Home Tel. _____ Work Tel. _____

How would you prefer to be addressed? _____

Gender Male / Female Student? NO / YES, FT / YES, PT

How did you hear about Boston Osteopathic Health? _____

EMAIL ADDRESS: _____

Relationship Status ___Single ___Married ___Live-in Partnership ___Separated ___Divorced ___Widowed

Insurance Information

Relationship to Insured ___Self ___Spouse ___Dependent

Primary Care Physician (Name/Address/Phone) _____

Insurance Company _____ Insured's Name _____

Address/Phone # _____ Address _____

Group Number _____ City/State/Zip _____

ID/Plan Number _____ Home Tel. _____

Insured's Employer _____ Insured's Birthdate _____/_____/_____

Is patient's condition related to work? YES / NO. If yes, date of injury ____/____/____ Name of Employer: _____

Is patient's condition related to an auto accident? YES / NO If yes, date of injury: ____/____/____

In Case of an Emergency

Name _____ Relationship _____

Address _____ Phone Number _____

City/State/Zip _____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____

Printed (Patient/Parent/Guardian) Signature Date

Cancellation Policy

Please let us know if you are not able to keep your scheduled appointment. We require 2 business days for cancellation.

- Cancellations made 2 business days or more before the appointment will not be charged.
- Cancellations made less than 2 business days will be charged $50.
- Cancellations made less than 24 hours will be charged half the cost of the appointment.
- Appointments missed without notification will be charged the full cost of the appointment.

Please be aware that these charges are not billable to any insurance company; you have to pay them yourself.

Of course, if you have a true emergency, (such as an injury or significant illness) we will waive the charge.

We will understand if you show up late, but please know that we have to end on time so that we are not cutting into someone else's time.

I have read and understand the above policy:

Name: _____ Date: _____

Signature: _____

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134 Rumford Avenue, Suite 208, Newton MA 02466

Health Information Consent

I give my consent to representatives of Boston Osteopathic Health to leave messages on my personal answering machine or with individuals that I designate below.

Relating to my care ____ Yes ___No

Appointment reminders ____Yes ___No

I give consent to representatives of Boston Osteopathic Health to discuss my care with the following individuals:

_____ (_____)_____
Spouse Name Phone number

_____ (_____)_____
Family member/ Relationship Phone number

_____ (_____)_____
Family member/ Relationship Phone number

_____ (_____)_____
Other/ Relationship Phone number

I understand and agree that this authorization will stay in effect until I notify Boston Osteopathic Health with written notice to change or withdraw my authorization.

Signature _____Date_____

Notice of Privacy Policies-Acknowledgement of Review

I have reviewed the Notice of Privacy Policies for Boston Osteopathic Health that explains my rights and documents policies and procedures that will safeguard my private health information.

Signature_____Date_____

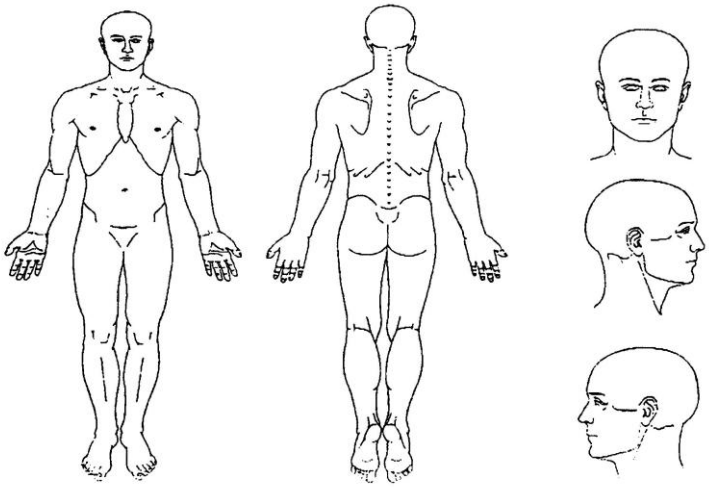
BOSTON OSTEOPATHIC HEALTH

Initial Office Visit/OMM consultation Date: _____

Patient Name: _____ DOB: _____
Primary care physician:_____ Occupation: _____
Referred by _____ for an osteopathic manipulative medicine consultation for below chief complaint.

Subjective:
Main Concern (chief complaint):_____

HPI:Onset/duration:_____ Location:_____
Description/quality:_____Pain score: 0 1 2 3 4 5 6 7 8 9 10_____
Gets better with:_____ Gets worse with:_____
Trauma/mechanism of injury:_____



you may draw on the diagrams to illustrate symptoms

BOSTON OSTEOPATHIC HEALTH

Patient Name: _____ Date: _____

Medical history: *list any current or past medical diagnoses*

_____

_____

Surgical history:

_____

_____

Medications: _____
Vitamins/supplements:_____
Allergies: (Drug, food, contact, seasonal): _____
Obstetrical history: How many pregnancies?_____ How many children do you have?_____
Trauma history:_____
Social history: Tobacco: y/n____ Alcohol: y/n____ Drugs: y/n____ Caffeine: y/n ____ Daycare/school: y/n____
Family history: Mother:_____ Father:_____ Siblings:_____
ROS: *circle any chronic or current symptoms, the remainder is negative*
Fatigue, weight loss, insomnia, blurry vision, change in vision, poor vision, ear pain, hearing loss, throat pain, hoarseness, sinus pain, nasal congestion, cough, shortness of breath, wheezing, chest pain, palpitations, nausea, vomiting, diarrhea, constipation, bloating, abdominal pain, acid reflux, urinary burning, incontinence, joint pain, muscle pain, headache, numbness, tingling, dizziness, muscle weakness, bruising, bleeding, hair loss, dry skin, intolerance to heat /cold, hot flashes, depression, anxiety, allergy to drug/environment/food

Physical Exam:
BP_____ Pulse_____ RR_____ Temp_____ Height_____ Weight _____ Pain_____
Appearance:_____Chest_____
Head:_____Eyes:_____
ENT:_____ Endo:_____
Cardiac:_____Resp:_____
Abd:_____ Lymph:_____
Neuro:_____
Extremities:_____
Skin:_____
Musculoskeletal/osteopathic structural:

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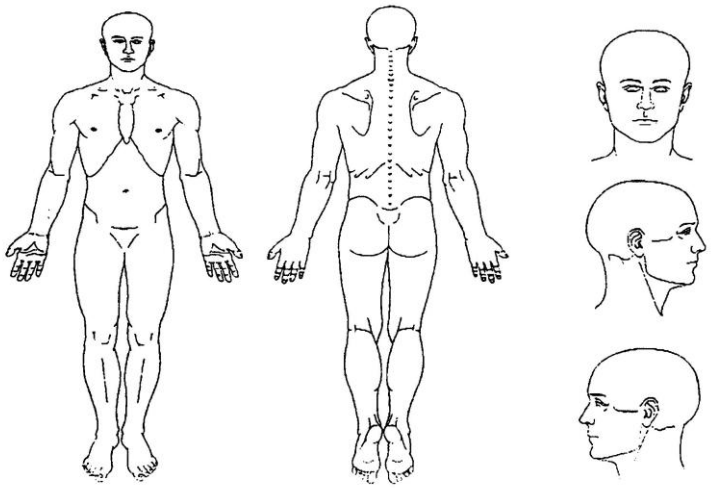

BOSTON OSTEOPATHIC HEALTH

Patient Name: _____ Date: _____

Region	Comments	Art	BLT	CS	FPR	HVLA	ME	MFR	OCF	PH	ST	Vis	oth
Head	OA SS R / L												
Neck													
Thoracic													
Lumbar													
Sacrum	SI Restricted R / L												
Pelvis	Innominate ant / pos R / L												
Lower ext													
Upper ext													
Rib													
Abd													

Assessment:

ICD9 code	Diagnosis	ICD9 code	Diagnosis
		739.0	Head
		739.1	Cervical
		739.2	Thoracic
		739.3	Lumbar
		739.4	Sacrum
		739.5	Pelvis
		739.6	Lower extremity
		739.7	Upper extremity
		739.8	Ribs
		739.9	Abdomen/other

Plan:

□ OMT discussed with patient/guardian including risks and benefits and consent was obtained for a trial for OMT.

OMT performed as above: 1-2 areas 3-4 areas 5-6 areas 7-8 areas 9-10 areas

OMT was tolerated well/poorly. *Visit length (in minutes) ≥ 10 20 30 45 60

The patient had: □ improved motion, □ decrease restriction, □ less pain, □ decreased symptoms after treatment.

Osteopathic treatment was directed not only to the primary area of complaint, but also the secondary, biomechanical compensatory pattern associated with the primary area.

**Patient was counseled for _____ minutes regarding_____

_____

_____

_____

_____

_____

_____

_____

Reevaluate and consider further treatment options in _____Days _____Wks _____Mos _____PRN

Physician: _____ Date: _____