Katherine J. Scoville, D.O. P.C.
311 North Street, Suite 307
White Plains, NY 10605
914-358-9559

Today's Date: _____

Please print the following information:
Name: _____ Date of Birth: _____/_____/_____
Address: _____ SS#: _____-_____-_____
_____ Email: _____
Phone #'s (Please check ( ) if OK to leave a message):
Home: _____( ) Work: _____( ) Cell: _____ ( )

Occupation: _____ Employer: _____
Insurance Company: _____ Policy Number: _____
Name on Policy: _____ Group Number: _____
Policy Holder's SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Secondary Insurance Company:_____ Policy Number: _____
Name on Policy: _____ Group Number: _____
Policy Holder's SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Spouse/Domestic Partner: _____
Closest Relative/Person to notify in case of an emergency: _____
Relationship: _____ Phone: _____

Referred by: _____
Allergies: _____

Physician from whom you are currently receiving medical care:

Physician	Phone number	Conditions under treatment	Medications

Surgeon	Date	Surgical procedure and reason performed

Are you currently on Disability? _____ Worker's Comp.? _____
Is the condition that you are seeking help for the result of a motor vehicle accident?

Race (Check one):
- o American Indian or Alaskan Native
- o Asian
- o Black or African American
- o Hispanic or Latino
- o Native Hawaiian or Other Pacific Islander
- o White
- o I choose not to specify

Preferred Language:_____

PLEASE READ AND SIGN THE NEXT TWO PAGES, AND FILL OUT ALL REMAINING PAGES. THANK YOU.

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Welcome:

To help you get acquainted with the office, we have prepared this statement about our policies and fee schedules. Please sign below to indicate that you have read and understand our guidelines.

Office Hours:
Mon: 10:00 am–8:00 pm., Wed: 8:00 am-8:00 pm, Thurs: 8:00 am-4:30 pm, Fri: 8:00 am–4:00 pm.

Your Appointment:
Your appointment is time set aside for you to see the Doctor. We have a ***twenty-four (24) hour cancellation policy***. If you cancel an appointment less than 24 hours prior to its scheduled time, you will be billed the full visit fee. A message may be left on our voice mail at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and endeavor to be punctual for your appointment.

Children:
Children *must be supervised by their caretaker and remain in the waiting area* unless they are being seen by the doctor.

Fragrances:
Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays; we would appreciate it if you would refrain from wearing these to the office.

Fees & Payments:
For all patients, we require payment for services at the time they are provided. We are unable to accept assignment from private insurance carriers, but we supply a standard, itemized receipt that you may submit to your non-Medicare insurance company to request reimbursement. Because Dr. Scoville has opted out of Medicare, Medicare patients will need to sign a Private Pay Contract, which the doctor will explain prior to treatment. The Contract affirms that the patient accepts responsibility for all treatment costs, and will not seek Medicare reimbursement. Our practice is not a Medicaid practice.

The parent or guardian of a minor patient is responsible for payment.

Checks returned from the bank will incur a $30.00 “returned check” fee to your account.

Thank you for taking the time to read this policy sheet. If you have any questions about our policy please ask them now.

We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above office policies and consent to treatment by Dr. Scoville and her staff.

_____	_____	_____
Signature of Patient or Authorized Guardian if under 18 years old	Print Name	Date

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Today's Date: _____

Name: _____Date of Birth: _____/_____/_____

1. **Permission to release information to Insurance Carriers:**

We must have your authorization in order to respond to any correspondence from your insurance carrier. Please sign below so that we may send out any needed information and/or letters to help you obtain reimbursement.

I give permission to this office to release medical information to my health insurance company.

Signature _____ Date _____

- ○ Please contact me when you receive **any** requests for information from my insurance carrier.
- ○ Please contact only when there are requests for copies of your office notes.

2. Permission to Share Information with Health Care Providers:

If you want the doctor to share your medical information with other health care providers so that we may function as a team please give permission by signing below. Please provide the names of these health care providers.

Signature _____ Date_____

- ○ Please contact me before sharing any information with my other health care providers.

2. Permission to Share Information with any other individuals:

If you want the doctor to share your medical information with other individuals, such as family members, please give permission by signing below. Please provide the names of these individuals.

Signature _____ Date_____

3. Patient Privacy Policy:

I have read and understand Dr. Scoville attached Patient Privacy Policy. In respect of patient's privacy and security, and the requirements of the Health Insurance Portability and Accountability Act (HIPAA), I agree to abide by the Patient Privacy Policy of this office.

_____	_____	_____
Signature of Patient or Authorized Guardian if under 18 years old	Print Name	Date

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Patient Privacy Policy

In order to protect sensitive personal and medical information, we have instituted a number of measures aimed at maintaining your privacy. The Health Insurance Portability and Accountability Act (HIPAA) that requires every medical provider to make available to patients a privacy policy. This effort is to maintain privacy of patient information in an era of high technology and data-laden medical systems. The end result will be a more streamlined system of medical information with a higher degree of information security in the process. The following is our office policy for patients of this office regarding patient privacy and confidentiality of information collected and stored in this office:

1. Payments and scheduling will be done by the office manager or Dr. Scoville. Patients must remain in the waiting area and NOT at the office manager's desk so that the scheduling book and computer screen are NOT visible to them.

2. An information sheet with demographic data, insurance information, consents for treatment and medical disclosure will be completed by every patient as part of his/her record. A copy of this sheet and the insurance card(s) will be released to the office manager for billing records and to help process medical claims. This form will include the patient's preferences for where appointment reminders may be left (home, work, or cell phones).

3. All super bills for office visits will be shared with the office manager/billing supervisor in order to process insurance claims and record business transactions for tax purposes.

4. Any paper trash with patient information will be shredded prior to discarding it.

5. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting which is not to be discussed or revealed to any unauthorized person(s)/business(es) outside of the office setting without prior written consent by the patient/legal guardian.

6. Medical release forms are required to be signed by the individual or parent/guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. A copying charge may apply for extensive record copying.

7. Only first names will be used when addressing patients in the office.

8. All medical related conversations will occur in private.

9. All papers related to patient care will be stored in cabinets when not in use where only authorized medical staff has access to them.

10. Any breach of confidentiality must be submitted in writing to Dr. Katherine Scoville personally for a proper action to be taken in regard to the situation.

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1. What problems cause you to consult the doctor today? (Describe your symptoms in detail.)

_____

_____

2. When did your symptoms begin? _____

3. Do you know what caused them? If so please explain. _____

4. If you have pain, has it increased or decreased since the onset? _____

5. What has helped relieve your symptoms? _____

6. What time of day are your symptoms most severe? _____

7. How many days a week do you experience your symptoms? _____

8. What type of treatment, medical or non-medical, have you received for this problem? _____
_____

9. How has this pain affected your life, at work, at home, and socially? _____

_____

TO WHAT EXTENT DOES PAIN OR PROBLEM AFFECT YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES:

Activity	0%	25%	50%	75%	100%	Activity	0%	25%	50%	75%	100%
Shampoo your hair						Stand					
Fasten buttons						Sleep					
Put on and tie shoes						Socialize					
Cut toe nails						Travel in a car					
Lift objects less that 20 pounds						Fulfill your job requirements					
Walk for > 15 minutes						Do laundry					
Sit in a car						Shop for groceries					
Lie down in bed						Gardening					

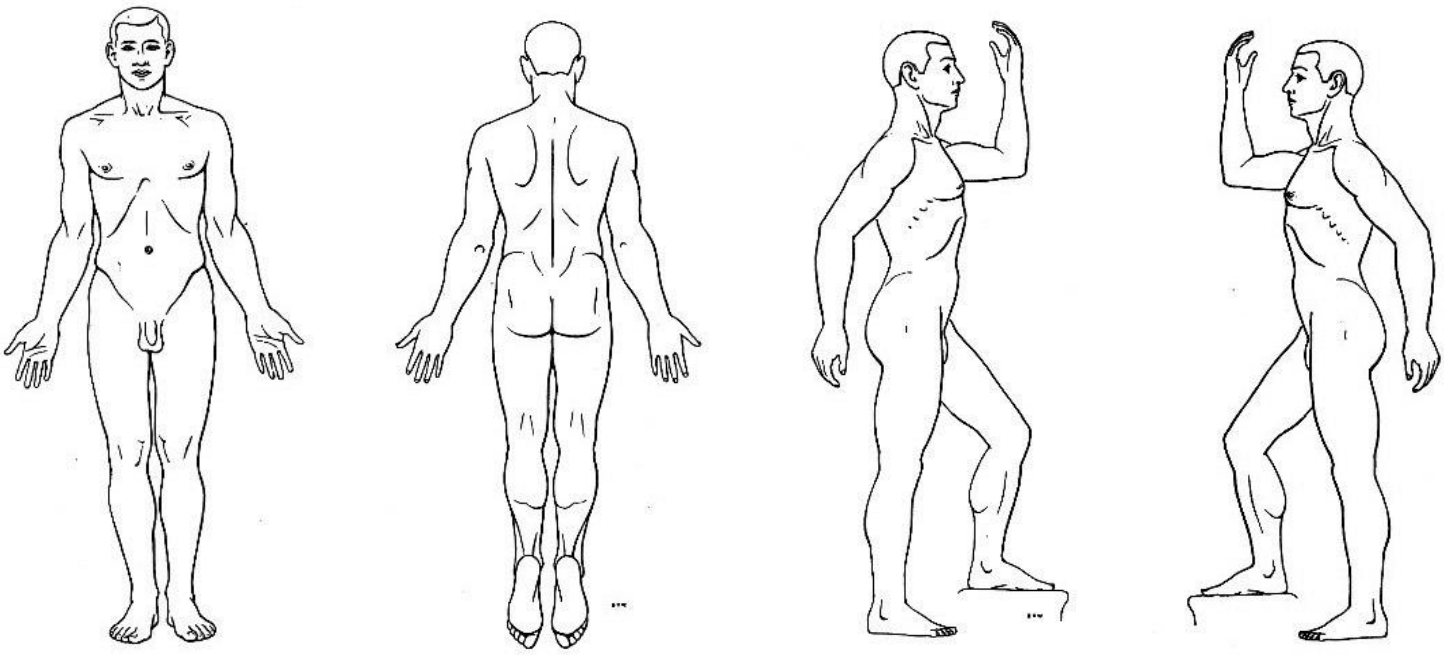
SOCIAL HISTORY AND HABITS:

Highest education level:
Occupation:
Military service: Yes No If yes, where?
Travel: (Type and frequency)
Hobbies:
Exercise program:
Alcohol Consumption: Amount per week and years used?
Drug use:(Marijuana, Heroin, LSD, Cocaine, Methamphetamine): Amount and how long used?
Tobacco use: How much per day and how many years used?
Caffeine consumption: (coffee, tea, carbonated soft drink, energy drinks) How many ounces per day?

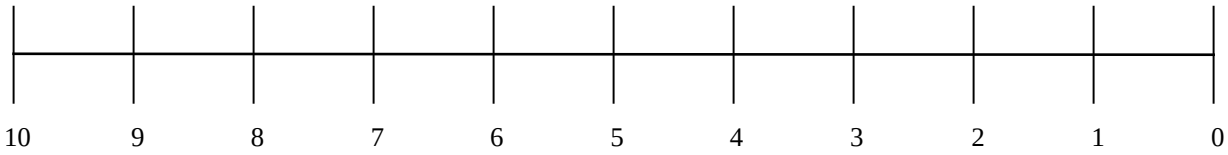
PATIENT MEDICAL HISTORY

LOCATE YOUR PAIN ON THE FIGURES BELOW, USING THE SYMBOLS GIVEN BELOW:

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	+ + +



If "10" = worst and "0" = no problem, Put an X on the scale below where you would rate yourself today:



MEDICATIONS YOU ARE CURRENTLY TAKING: (prescription and over the counter)

Name	Dosage	Frequency	Years Used
1.			
2.			
3.			
4.			
5.			

On the back of this page, please list other meds that you have taken in the past that were not helpful.

ALERGIC REACTIONS TO:	What symptoms did you have with the reactions?
1. Drugs:	
2. Foods:	
3. Chemicals and Environmental Factors:	
4. Animals:	

PATIENT MEDICAL HISTORY

MOST RECENT STUDIES OR TESTS:

Study or Test	Date	Study or Test	Date	Study or Test	Date
Mammography		Physical Exam By whom?		Others	
Complete Blood Count					
Pap Smear		TB Test			
Flexible Sigmoidoscopy		Cholesterol			
Colonoscopy		Blood Chemistry			
EKG		Urinalysis			
Hemoccults					

FAMILY HISTORY: Pleas indicate which of your family members have had any of the following:
Allergies, Bleeding Tendencies, Cancer (give location and type), Diabetes, Epilepsy, Heart Disease, High Blood Pressure, Kidney Disease, Mental Illness, Lung Disease, Stroke, or Tuberculosis.

Relative	Age if Living	Health Problem	Age of Onset	Age of Death	Cause of Death
Paternal GM					
Paternal GF					
Maternal GM					
Maternal GF					
Father					
Mother					
Brothers					
Sisters					
Children					

REVIEW OF SYSTEMS: Indicate "C" if it is a current problem and "P" if it is a past problem

C	P	1. SKIN:	C	P	3. HEAD:	C	P	4. EYES: (continued)
		Color change			Trauma			Color blindness
		Texture change			Headache			Glaucoma
		Moisture Change			Dizziness or light-headed			Cataracts
		Sores			Fainting			Wear glasses/contacts
		Itching			Loss of consciousness			Date of last refraction
		Severe acne			Feeling of spinning	C	P	5. Ears (R or L or Both?)
		Cancer			Seizure disorder			Hearing loss
		Easy bruising/bleeding	C	P	4. EYES (R or L or Both?)			Use of hearing aid(s)
		Change in Fingernails			Itching			Ringing in ears
		Hair loss/distribution			Watering or dryness			Ear pain
		Oiliness (skin, hair, scalp)			Discharge or crusting			Discharge
C	P	2. LYMPHNODES: (B or L?)			Double vision			Excess wax
		Enlargement			Sensitive to light			Recurrent infections
		Redness (inflammation)			See halos around light or floaters			Mastoiditis
		Pain or tenderness			Change in vision			Motion sickness

PATIENT MEDICAL HISTORY

C	P	6. NOSE:	C	P	9. CARDIOVASCULAR	C	P	11. GASTROINTESTINAL (cont.)
		Trauma			Blood clots in the lungs			Bowel movements during night
		Sinusitis			High blood pressure			Constipation
		Excess nasal drainage			Chest pressure or tightness			Straining with bowel movements
		Stuffiness			Chest pain or heaviness			Diarrhea
		Obstruction			Chest discomfort (exertional)			Use of antacids or laxatives
		Post-nasal drainage			Palpitations			Black stools
		Nosebleed			Rapid heart rate at rest			Grey or yellow stools
		Smell (decrease or loss of)			Irregular heart rate			Rectal pain or discomfort
		Mouth breather			Heart murmur			Rectal itching
		Frequent colds			Swollen ankles/feet in evening			Hemorrhoids
		Snoring			Leg cramps when sleeping			Rectal bleeding
C	P	7. MOUTH / THROAT/ NECK			High cholesterol or fats			Anal Fissures
		Trauma			Blue hands or feet			Hernia (umbilical or hiatal)
		Sores in mouth			Calf pain while walking			Yellow skin (jaundice)
		Bleeding or infected gums			Cold hands or feet			Gall stones or GB disease
		Sore tongue	C	P	10. BREASTS (R or L or both)			Pancreatitis
		Dental cavities			Pain and tenderness	C	P	12. URINARY TRACT:
		Frequent sore throats			Swelling			Difficulty / inability to urinate
		Difficulty swallowing			Lumps or masses			Infrequent, sm. Amt. of urine
		Persistent hoarseness			Nipple retraction			Frequent urinary tract infections
		Change of taste			Nipple discharge or bleeding			
		Bad breath			Frequency of self-examination			Flank pain
		Big tonsils / adenoids	C	P	11. GATROINTESTINAL			Kidney infection / nephritis
		Thyroid enlargement			Wt. loss/gain in the last year			Kidney or bladder stones
		Neck pain or tenderness			Loss of appetite			Hernia: L or R inguinal or femoral
C	P	8. RESPIRATORY			Compulsive eater			
		Asthma			Stomach / duodenal ulcers			Sexually transmitted disease
		Pneumonia			Heartburn			Sexual problems you wish to Discuss with the doctor?
		Bronchitis			Indigestion			
		Emphysema			Food intolerances			Frequent urination
		Cough			Bloating or belching			No. of times you urinate at night
		Sputum (amount and color)			Flatulence (passing gas)			Cloudy urine
		Cough up blood			Nausea			Dribbling
		Shortness of breath (@ rest)			Vomiting			Urgency / loss of control
		Shortness of breath (exertion)			Vomiting blood			Hesitancy

PATIENT MEDICAL HISTORY

C	P	19. OB / GYNECOLOGY:	C	P	14. MALE GENITALIA (cont.)	C	P	16. PSYCHOLOGICAL (cont.)
		When was the first day of Your last period?			Sexual dysfunction or impotence			Problems (with spouse / family)
								Previous psychiatric care
		At what age did you have Your first menstrual period?			Testicular mass (R or L?)			Do you desire psychiatric care?
		How many days do you Flow?			Decreased force of urinary stream			Cry often
								Worrier
		Menstrual cramps			Difficulty starting or Stopping flow of urine			Perfectionist
								Difficulty making decisions
		Hot flashes	C	P	15. NEUROLOGICAL:			Consider / attempted suicide
		Painful intercourse			Head injury			Difficulty sleeping
		Vaginal discharge			Frequent headaches	C	P	17. MUSCULOSKELETAL
		Vaginal dryness			Loss of consciousness			Trauma (fracture / dislocation)
		Sores on external genitalia			Fainting			Car accident
		Infertility problems			Numbness (location?)			Decreased range of motion
		Breast feeding			Tingling (location?)			Loss of strength
		Contraceptive use: (type?)			Weakness (location?)			Stiff or aching muscles / joints
		No. of pregnancies			Tremors			Neck ache / pain
		No. of live births			Convulsions			Backache / pain
		No. of living children			Twitching			Arm or hand pain
		No. of abortions (miscarriages)			Difficulty walking			Numbness / tingling (where?)
		Complications (with pregnancies or deliveries)			Speech abnormalities			Sciatic pain (R or L?)
					Decrease / loss of sensation			Arthritis
C	P	14. MALE GENITALIA:			Sleep disturbances			Swollen joints
		Urethral discharge	C	P	16. PSYCHOLOGICAL			Join pain
		Sores on penis or scrotum			Nervousness / anxious			Blow to the head
		Testicles tender (R or L?)			Sensitive			A fall on your buttocks?
		Enlarged prostate			Depressed			
		Prostatitis			Fatigue			
		Elevated PSA			Memory change			

For Physician's use:
