

# Osteopathy Matters, PLLC

Welcome to our office!

## Patient Information

Full Name: \_\_\_\_\_ Mr. / Mrs. / Ms. / Miss / Dr.  
(Last) (First) (M.I.)

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ message ok? Y / N

Preferred method of contact \_\_\_\_\_ Please send appointment reminders via email \_\_\_\_\_ text \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Currently Smoking: Yes / No

Please list medical problems:

\_\_\_\_\_  
\_\_\_\_\_

Current List of Medications (please include dosage and frequency):

- |            |            |
|------------|------------|
| 1.) _____  | 2.) _____  |
| 3.) _____  | 4.) _____  |
| 5.) _____  | 6.) _____  |
| 7.) _____  | 8.) _____  |
| 9.) _____  | 10.) _____ |
| 11.) _____ | 12.) _____ |

## Emergency Contact

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

***Acknowledgement of Receipt of Privacy Policy: I acknowledge that I have received a copy of Osteopathy Matters PLLC's Privacy Practices.***

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Osteopathy Matters, PLLC does not participate with any insurance carrier. Osteopathy Matters, PLLC is considered a provider, non-participator with Medicare and will submit claims on your behalf. Payment is due at the time of your visit.**

## **Medicare Information**

Medicare Insured Name: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

*I give my permission to Osteopathy Matters to submit claims to Medicare directly for any services provided by Dr. Maria Budner-Gentry or Dr. M.A Teves (reimbursement will be mailed to insured by Medicare)*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_