

Daniel A. Shadoan, D.O. Matthew Gilmartin, M.D. Elliott S. Blackman, D.O.
Sean Radan, L.Ac.

1956 Union Street, San Francisco, CA 94123
tel: (415) 921-1446 fax: (415) 921-0215

Please fill out as much as possible of your medical history and contact information as well as the HIPAA form. You can bring them with you to your initial appointment, or fax or mail them back to us beforehand if you prefer. I am also including a sheet with directions and parking info- Thanks!

Registration Information

Please Print

Date: _____

Name: _____

Address: _____

City: _____ Zip Code: _____

Birth Date: _____ Sex: _____

Occupation: _____

Cell: _____ Home tel: _____

or Work Phone: _____

(If we have your cell number and are running behind schedule, I can call to let you know.)

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Policies:

- We do not accept Medicare, Worker's Comp or HMOs (including Kaiser). You will not be reimbursed by Medicare or Medigap plans, although some Supplemental plans may reimburse for some part of our fees. Dr. Gilmartin is unable to see Medicare patients at this time.
- We do not bill insurance directly – you will receive a bill to mail to your insurance. Reimbursement is likely only from auto insurance (usually 100%) or PPO policies, 20-70% once deductible has been met.
- We accept cash or check only, (no credit or debit cards).
- We request 24 hour notice for cancellations, otherwise the usual fee will be charged. As a courtesy, we will call 1-2 days in advance of upcoming appointments.
- Please wear comfortable, loose clothing- no jeans or skirts/dresses.

Location:

- 1956 Union, north side of the street between Laguna & Buchanan
- Down walk-way, between two buildings, hidden from view.
- Blue & white real estate sign SALMA & CO. spans our walk-way.
- Stay to right below "Integrative Medicine/ 1956 Union" sign. Go to second-floor office in the back cottage - up 20 stairs and in wooden door at top.

Directions by Public Transportation:

BART: from Powell St. take MUNI Bus #45, leaving from 3rd St. between Mission and Market to Union and Laguna. Walk ½ block west on Union to our office (past the Wells Fargo Bank). From Civic Center, take any Van Ness bus Northbound to Union. Either take the #45 Union west or walk 4 blocks west to office.

MUNI: #45 and #41 stop on Union and Buchanan, #22 stops at Fillmore and Union, #28 and #43 stop at Lombard and Fillmore. #47 and #49 stop at Van Ness and Union

GOLDEN GATE TRANSIT: many buses from Marin stop at Lombard and Fillmore.

Directions By Car:

80W (from East Bay) or 101N (from the Peninsula): Take Octavia St. exit off of 101 and go straight 4 blocks and turn left onto Fell. Take first right onto Laguna and continue 24 blocks. Turn left onto Union. The office is half way down block on right (North) side of street.

280N (from Peninsula): Entering city, stay to left towards Hwy 1 Northbound and 19th Ave. Continue with main traffic flow veering left onto 19th Ave. In Golden Gate Park, stay to right and continue onto Park Presidio Blvd. Turn right onto California St. and continue about 16 blocks, then turn left on Divisadero. Go over the hill and turn right onto Union St. The office is about 7 blocks on the left side of the street.

101S (from Marin): Take Golden Gate Bridge and continue to Lombard St. exit to the right ½ mile. After freeway ends, continue on Richardson as it veers left to become Lombard. Turn right onto Buchanan, go 3 blocks and turn left onto Union St. The office is halfway down block on left (North) side.

Parking:

- Meters on Union St. are 8 minutes per quarter and meter maids check often.
- Side streets have 2-hour free parking, but watch for street cleaning hours.
- Parking Lots:
 - o Closest lot - on our block - next to Wells Fargo (most expensive).
 - o 2001 Union Building lot near Buchanan (slightly less expensive).
 - o Above the Lombard Post Office- enter in Moulton alley near Webster and Lombard.
 - o Outdoor lot on Lombard between Webster and Buchanan, \$10 for all day.

Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

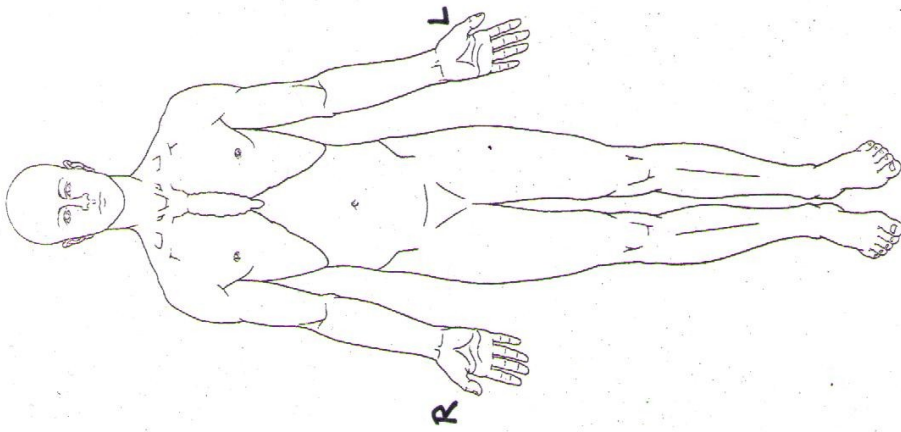
I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

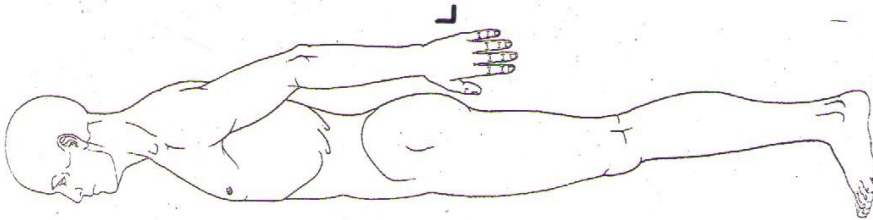
Signature: _____ Date: _____

Patient, parent or legal guardian

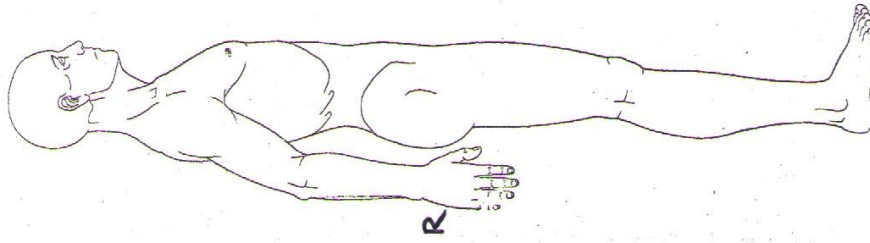
If signed by patient representative, state relationship to patient _____



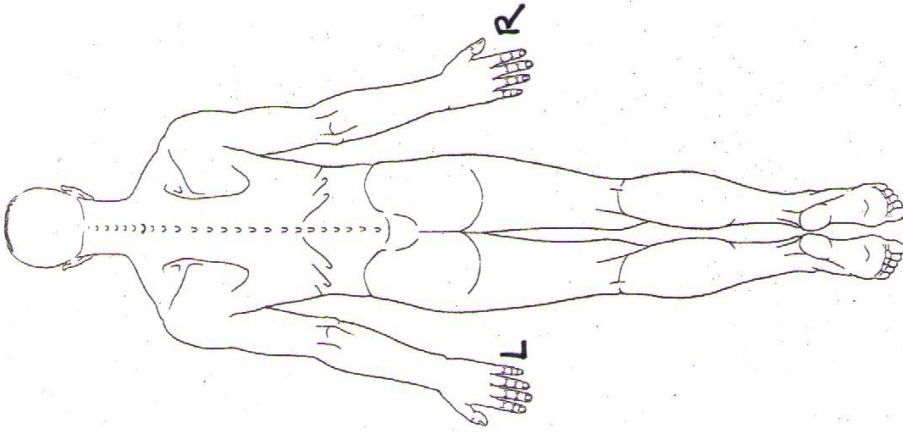
Front



Left Side



Right Side



Back

Please mark areas of pain/concern with an X.

Circle any areas of numbness/tingling.

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PEDIATRIC QUESTIONNAIRE

(PLEASE ANSWER AS MUCH AS POSSIBLE)

Parent's Name: _____ Today's Date: _____

Child's Name: _____ Age: _____ Birthdate: _____

Medications: _____

Allergies to medications: _____

Surgeries: _____

Traumas/Accidents/Injuries: _____

Illnesses/Hospitalizations: _____

Mother's age at delivery _____ Baby's gestational age at delivery (in weeks) _____

Number of older siblings _____ Number of younger siblings _____ Pregnancy planned: *Yes No*

Medicines/caffeine/tobacco/alcohol used during pregnancy: _____

Delivery: Hours of Labor _____

Time Pushing: _____ Medicines used during labor: _____

Epidural: *Yes No* Pitocin augmentation: *Yes No* Forceps: *Yes No* Vacuum: *Yes No*

C-section: *Yes No* Reason: _____

Presentation: Vertex (Head) _____ Breech (Feet) _____ Transverse (Side) _____

APGAR _____ First Cry: strong weak Wt _____ Head Circumference _____

Length _____

Complications Mom: _____

Complications Baby: _____

Immediate to breast? *Yes No* *Breast or Bottle* Strong suck: *Yes No* Spit-up: *Yes No*

Vomit: *Yes No* Failure to thrive: *Yes No* Formula(s) _____ *Yes No*

Colic: *Yes No* Sleep well: *Yes No* Age first slept through the night _____

Start solids: *Yes No* Age _____ Able to feed self: *Yes No*

Was baby placed on belly as infant? *Yes No*

Personality: _____

Milestone	Age Completed	Milestone	Age completed
Smile		Sit w/support	
Coo		Crawl/creep	
Reach For		Cruise	
Babble		Walk	
First Word		Climb stairs	
2-4 Words		Climb Stairs alternate feet	
Toilet train		Feed self	

Typical Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Food intolerancys/allergies: _____

_____ Water intake (glasses per day) _____ Supplements: _____

Interests/Hobbies/School: _____

Medical Problems in Family: _____

Pediatrician:

Other Osteopath and/or Homeopath:

Other Specialists or Therapies:

Reviewed by: _____ Date _____