

# The Connecticut Center for Health

New Patient Questionnaire – First Visit

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE DO NOT MAIL QUESTIONNAIRE. BRING IT WITH YOU TO YOUR APPOINTMENT.**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Do you have a name you prefer to be called by? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ – \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work \_\_\_\_\_ Fax# \_\_\_\_\_

Email \_\_\_\_\_

Social Security Number \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_ What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_

How did you learn about the Center? \_\_\_\_\_

Level of Education? (Check) \_\_\_\_\_ High School \_\_\_\_\_ College \_\_\_\_\_ Graduate School

Do you give us permission to share findings and converse with your primary doctor and other providers?  Yes  No

Are you employed? Yes or No If yes, what is your occupation? \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Are you covered by medical insurance? Yes or No If yes, who? \_\_\_\_\_

Is this your “**primary**” insurance coverage? Yes or No

Your Insurance ID # \_\_\_\_\_ Group Name or # \_\_\_\_\_

Who’s Name is the insurance in? (the subscriber) \_\_\_\_\_ ID# \_\_\_\_\_

Who will be responsible for payment of services? \_\_\_\_\_

Name of spouse, parent, relative, friend, or significant other \_\_\_\_\_

**What health concerns would you like to discuss in your initial visit? Please list your concerns in order of importance.**

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_

4. \_\_\_\_\_ 8. \_\_\_\_\_

**What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your symptoms? Please explain. (You may attach additional pages if necessary.)**

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When was the last time you experienced optimal health? \_\_\_\_\_

Please write the specific health results you would like to achieve in working with the doctor. \_\_\_\_\_

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

Have you ever been hospitalized? Yes or No If yes, please provide specifics where indicated below.

Condition Treated or Surgical Procedure Performed	Date	Hospital
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

Are you allergic to any foods, drugs or other substances? If yes, please list.

Food\Drug\Substance	Allergic Reaction(s)
_____	_____
_____	_____
_____	_____

Date of last physical exam? \_\_\_\_\_ Date of last chest x-ray? \_\_\_\_\_ Blood work performed? Yes or No

Do you smoke cigarettes? If yes, list # of cigarettes or packs per day \_\_\_\_\_

Do you use any other tobacco products? List \_\_\_\_\_

Do you have an alcoholic family member or loved one? Yes or No If yes, who? \_\_\_\_\_

Do you drink alcohol? Yes or No If yes list type(s) \_\_\_\_\_

Daily or weekly amount of alcohol consumed? \_\_\_\_\_

Do you exercise? If yes, what type(s)? \_\_\_\_\_

If yes, times/week? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you use recreational drugs or marijuana? If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_

Are you sexually active? Yes or No Do you use protection during sexual activity? Yes or No

Have you had any sexually transmitted diseases? If yes please list \_\_\_\_\_

How many hours do you sleep nightly? \_\_\_\_\_ What time do you fall asleep? \_\_\_\_\_ What time do you awake? \_\_\_\_\_

How would you characterize your sleep? (circle) Fitful Erratic Calm Restful Deep

Upon awakening, do you feel well rested and energetic? Yes or No Do you nap during the day? If yes, how long? \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Is any blood relative or member of your immediate family presently experiencing any of the following conditions? Please use the following codes to denote the person affected. **M** for your Mother. **F** for your Father. **B** for your Brother. **S** for your Sister. **GM** for your Grandmother. **GF** for your Grandfather. **A** for your Aunt. **U** for your Uncle. **W** for your Wife. **H** for your Husband. **SO** for your Significant Other.

<b>PAST</b>	<b>PRESENT</b>	<b>CONDITION</b>	<b>PAST</b>	<b>PRESENT</b>	<b>CONDITION</b>
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	Herpes
___	___	Asthma	___	___	High Blood Pressure
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Injury (Life-Threatening)
___	___	Cancer	___	___	Kidney Disease
___	___	Colitis	___	___	Liver Disease
___	___	Constipation	___	___	Lyme Disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

**PERSONAL HEALTH HISTORY** Please indicate any condition(s) of past or present concern:

<b>PAST</b>	<b>PRESENT</b>	<b>CONDITION</b>	<b>PAST</b>	<b>PRESENT</b>	<b>CONDITION</b>
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	Herpes
___	___	Asthma	___	___	High Blood Pressure
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Injury (Life-Threatening)
___	___	Cancer	___	___	Kidney Disease
___	___	Colitis	___	___	Liver Disease
___	___	Constipation	___	___	Lyme Disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

**OCCUPATION** If presently employed, how many hours per week do you work? \_\_\_\_\_

Describe the nature of your work and the responsibilities associated with it. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is your **stress level at work** ? (circle) Non-Existent Low Mild Moderate High Severe

What is your **satisfaction level at work?** (circle) Non-Existent Low Mild Moderate High Extremely High

Are you doing the **type of work that you would most enjoy** above all else? Yes or No

Do you work indoors? Yes or No Do you work in an office building? Yes or No

Do the windows open for ventilation? Yes or No Is there specialized air filtration in your workplace? Yes or No

Do you presently **work with chemicals or in the presence of toxic fumes?** Yes or No Have you ever? Yes or No

If Yes, list \_\_\_\_\_

What are you willing to do to achieve the health results you just recorded? If your physician were to recommend the following choices which would you be able to follow and comply with or not? Please check YES or NO.

ITEM	YES	NO	ITEM	YES	NO
Make dietary modifications			Take nutritional supplements daily		
Avoid certain foods			Be compliant with the treatment		
Exercise Regularly			Stick with the program for at least 6 months		
Read books, handouts or listen to tapes for self education about health			Keep the doctor informed about what part of the program is and is not working for you		

If you are in a relationship, will your **significant other support you** in your dietary or lifestyle modification(s)? Yes or No

Do you feel you are adequately loved by others?  Yes  No

Can you accept love when others offer it or demonstrate it?  Yes  No

Do you have people in your life that you love?  Yes  No

Do you experience joy and happiness on a regular basis?  Yes  No

Are you passionate about and fulfilled by some aspect of your life, such as work, a hobby, family, some combination of, etc.?  Yes  No

Are you sexually satisfied?  Yes  No Is this important to you?  Yes  No

Are you a "relaxed" person?  Yes  No Do you know how to relax?  Yes  No

Please review this list of conditions, **CHECK ONLY THOSE ITEMS YOU ARE EXPERIENCING PRESENTLY.**

- |                          |   |                          |                                      |
|--------------------------|---|--------------------------|--------------------------------------|
| <input type="checkbox"/> | Rough, Dry or Scaly Skin                  | <input type="checkbox"/> | Fever or Chills                      |
| <input type="checkbox"/> | Psoriasis or Eczema                       | <input type="checkbox"/> | Intolerance to Heat                  |
| <input type="checkbox"/> | Itching Skin                              | <input type="checkbox"/> | Intolerance to Cold                  |
| <input type="checkbox"/> | Pimples                                   | <input type="checkbox"/> | Excessive Hunger                     |
| <input type="checkbox"/> | Brittle Nails                             | <input type="checkbox"/> | Inability to Gain Weight             |
| <input type="checkbox"/> | Burning Skin                              | <input type="checkbox"/> | Change or Loss of Sensation          |
| <input type="checkbox"/> | Boils or Canker Sores                     | <input type="checkbox"/> | Loss of Balance                      |
| <input type="checkbox"/> | Skin Rash                                 | <input type="checkbox"/> | Seizures or Epilepsy                 |
| <input type="checkbox"/> | Skin Color Change                         | <input type="checkbox"/> | Shaking or Trembling                 |
| <input type="checkbox"/> | Hair Color Change                         | <input type="checkbox"/> | Lightheadedness upon Standing        |
| <input type="checkbox"/> |   | <input type="checkbox"/> | Severe Headaches                     |
| <input type="checkbox"/> | Numbness                                  | <input type="checkbox"/> | Fainting Spells                      |
| <input type="checkbox"/> | Paralysis                                 | <input type="checkbox"/> | Trauma or Injury to the Head         |
| <input type="checkbox"/> | Loss of Memory                            | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Lack of Coordination                      | <input type="checkbox"/> | Unexplained Fever                    |
| <input type="checkbox"/> | Nervousness                               | <input type="checkbox"/> | Burst of Energy Following Exercise   |
| <input type="checkbox"/> | Anxiety                                   | <input type="checkbox"/> | Difficulty Concentrating             |
| <input type="checkbox"/> | Depression                                | <input type="checkbox"/> | Difficulty Sleeping                  |
| <input type="checkbox"/> | Mood Swings                               | <input type="checkbox"/> | Difficulty Relieving Stress          |
| <input type="checkbox"/> | Restlessness                              | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Fitful Sleep                              | <input type="checkbox"/> | Dizziness                            |
| <input type="checkbox"/> | Hallucinations                            | <input type="checkbox"/> | Pain in Ears                         |
| <input type="checkbox"/> |   | <input type="checkbox"/> | Ringing in Ears                      |
| <input type="checkbox"/> | Muscle Cramps                             | <input type="checkbox"/> | Excessive Earwax                     |
| <input type="checkbox"/> | Muscle Weakness                           | <input type="checkbox"/> | Frequent Ear Infections              |
| <input type="checkbox"/> | Joint Pain, Stiffness or Swelling         | <input type="checkbox"/> | Discharge from Ears                  |
| <input type="checkbox"/> | Neck Pain                                 | <input type="checkbox"/> | Loss of Hearing                      |
| <input type="checkbox"/> | Upper Back Pain                           | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Lower Back Pain                           | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Backache                                  | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Frequent Fracturing of Bones              | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> |   | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Unexplained Weight Gain or Loss           | <input type="checkbox"/> | Dry Eyes                             |
| <input type="checkbox"/> | Overweight                                | <input type="checkbox"/> | Damp Eyes                            |
| <input type="checkbox"/> | Chronic Fatigue                           | <input type="checkbox"/> | Caked or Crusted Eyelids             |
| <input type="checkbox"/> | Increased Thirst                          | <input type="checkbox"/> | Sensitivity to Light                 |
| <input type="checkbox"/> | Night Sweats                              | <input type="checkbox"/> | Poor Eyesight                        |
| <input type="checkbox"/> | Wounds Slow to Heal                       | <input type="checkbox"/> | Cataracts                            |
| <input type="checkbox"/> | Swelling of Neck                          | <input type="checkbox"/> | Glaucoma                             |
| <input type="checkbox"/> | Stiff Neck                                | <input type="checkbox"/> | Change in Vision                     |
| <input type="checkbox"/> |   | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Neck Pain                                 | <input type="checkbox"/> | Double Vision                        |
| <input type="checkbox"/> | Goiter                                    | <input type="checkbox"/> | Blurred Vision                       |
| <input type="checkbox"/> | Unusual Growths of Hair                   | <input type="checkbox"/> | Loss of Vision                       |
| <input type="checkbox"/> |   | <input type="checkbox"/> | Eye Pain                             |
| <input type="checkbox"/> |   | <input type="checkbox"/> |                                      |
| <input type="checkbox"/> | Post Nasal Drip                           | <input type="checkbox"/> | Sore Gums                            |
| <input type="checkbox"/> | Sinusitis                                 | <input type="checkbox"/> | Sore Throat                          |
| <input type="checkbox"/> | Discharge from Nose                       | <input type="checkbox"/> | Sore Mouth or Tongue                 |
| <input type="checkbox"/> | Discharge from Nose During or After Meals | <input type="checkbox"/> | Sensitive Teeth                      |
| <input type="checkbox"/> | Nose Bleeds                               | <input type="checkbox"/> | Impairment or Loss of Sense of Taste |
| <input type="checkbox"/> | Difficulty Breathing Through Nose         | <input type="checkbox"/> | Increase or Decrease of Saliva       |
| <input type="checkbox"/> | Obstruction of Nose                       | <input type="checkbox"/> | Persistent Hoarseness                |
| <input type="checkbox"/> | Impairment or Loss of Sense of Smell      | <input type="checkbox"/> | Difficulty Speaking                  |

Please review this list of conditions, **CHECK ONLY THOSE ITEMS YOU ARE EXPERIENCING PRESENTLY.**

- |                          |  |                          |   |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | Frequent or Daily Coughs                                 | <input type="checkbox"/> | Constipation                                      |
| <input type="checkbox"/> | Frequent Colds   | <input type="checkbox"/> | Diarrhea  |
| <input type="checkbox"/> | Shortness of Breath at Rest                              | <input type="checkbox"/> | Rectal Pain                                       |
| <input type="checkbox"/> | Shortness of Breath at Play                              | <input type="checkbox"/> | Hemorrhoids                                       |
| <input type="checkbox"/> | Wheezing   | <input type="checkbox"/> | Jaundice  |
| <input type="checkbox"/> | Asthma   | <input type="checkbox"/> | Hepatitis   |
| <input type="checkbox"/> | Emphysema  | <input type="checkbox"/> | Gallbladder Problems                              |
| <input type="checkbox"/> | Bronchitis   | <input type="checkbox"/> | Difficulty Swallowing                             |
| <input type="checkbox"/> | Tuberculosis   | <input type="checkbox"/> | Vomiting  |
| <input type="checkbox"/> | Discharge from Throat Containing Blood and/or Mucus      | <input type="checkbox"/> | Vomiting Blood                                    |
| <input type="checkbox"/> | Chest Pain at Rest                                       | <input type="checkbox"/> | Loss of Appetite                                  |
| <input type="checkbox"/> | Chest Pain at Play                                       | <input type="checkbox"/> | Frequently Awake at Night Hungry                  |
| <input type="checkbox"/> | Heart Murmur   | <input type="checkbox"/> | Irritable if Late for a Meal                      |
| <input type="checkbox"/> | Heart Palpitations                                       | <input type="checkbox"/> | Sudden Cravings for Sweets or Alcohol             |
| <input type="checkbox"/> | Swelling of Ankles                                       | <input type="checkbox"/> | Headaches or Tremors Relieved by Consuming Sweets |
| <input type="checkbox"/> | Rheumatic Fever  | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Sleep in an Upright Position                             | <input type="checkbox"/> | Frequent Heartburn or Indigestion                 |
| <input type="checkbox"/> | Frequently Awake at Night Short of Breath                | <input type="checkbox"/> | Frequent Stomach or Abdominal Pain                |
| <input type="checkbox"/> |  | <input type="checkbox"/> | Frequent or Excessive Belching                    |
| <input type="checkbox"/> | Frequent Urination                                       | <input type="checkbox"/> | Frequent or Severe Nausea                         |
| <input type="checkbox"/> | Frequent Night Urination                                 | <input type="checkbox"/> | Discomfort After Fatty or Greasy Meals            |
| <input type="checkbox"/> | Frequent Urgent Urination                                | <input type="checkbox"/> | Lack of Energy After Meals                        |
| <input type="checkbox"/> | Painful Urination  | <input type="checkbox"/> | Black Stools                                      |
| <input type="checkbox"/> | Difficulty Holding Urine                                 | <input type="checkbox"/> | Yellow Stools                                     |
| <input type="checkbox"/> | Difficulty Initiating Urination                          | <input type="checkbox"/> | Blood in Stools                                   |
| <input type="checkbox"/> | Frequent Urinary Infections                              | <input type="checkbox"/> | Malodorous Stools                                 |
| <input type="checkbox"/> | Kidney Stones  | <input type="checkbox"/> | Anal Itching                                      |
| <input type="checkbox"/> |  | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Abdominal Bloating                                       | <input type="checkbox"/> | Discharge from Penis                              |
| <input type="checkbox"/> | Excessive Lower Bowel Gas                                | <input type="checkbox"/> | Difficulty Achieving or Maintaining Erection      |
| <input type="checkbox"/> | Stomach Pain 5 - 6 Hours After Meal (Usually at Night)   | <input type="checkbox"/> | Painful Erection                                  |
| <input type="checkbox"/> | Symptoms Above Relieved By Drinking Milk                 | <input type="checkbox"/> | Difficulty Ejaculating                            |
| <input type="checkbox"/> | Symptoms Above Aggravated by Worry or Tension            | <input type="checkbox"/> | Lumps, Swelling or Pain in Testicles or Groin     |
| <input type="checkbox"/> |  | <input type="checkbox"/> | Cold Hands and/or Feet                            |
| <input type="checkbox"/> | Discharge from Vagina                                    | <input type="checkbox"/> | Troubling Veins in Legs                           |
| <input type="checkbox"/> | Difficulty Feeling Sexually Aroused                      | <input type="checkbox"/> | Pain in Legs                                      |
| <input type="checkbox"/> | Lack of Lubrication When Aroused                         | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Never or Seldom Experience Orgasm                        | <input type="checkbox"/> | Swollen or Painful Lymph Nodes                    |
| <input type="checkbox"/> | Find Sexual Intercourse to be Painful                    | <input type="checkbox"/> | Easily Bruised                                    |
| <input type="checkbox"/> |  | <input type="checkbox"/> | Bleeding  |
| <input type="checkbox"/> | Menstrual Flow is Excessive/Decreased/Absent             | <input type="checkbox"/> | Anemia  |
| <input type="checkbox"/> | Bleeding or Spotting Between Periods                     | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Pain Before, During and/or After Periods                 | <input type="checkbox"/> |   |
| <input type="checkbox"/> | PMS (Cramping, Headaches, Water Retention)               | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Rheumatic Fever  | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Must Sleep in an Upright Position                        | <input type="checkbox"/> |   |
| <input type="checkbox"/> |  | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Clots in Menstrual Flow                                  | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Mood Swings/Changes with Menstruation                    | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Increased Acne, Irritability or Weight with Menstruation | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Pelvic Pain  | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Lumps or Pain in Breasts                                 | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Discharge from Breasts                                   | <input type="checkbox"/> |   |

## Please Read - Patient Information and Responsibilities

**IF WE PARTICIPATE WITH YOUR INSURANCE YOU MUST HAVE YOUR INSURANCE CARD WITH YOU AT THE TIME OF YOUR VISIT.** If your insurance requires a **A Referral**, and you do not have one in place when you arrive for your office visit you will be required to pay for your office visit in full at the time of service.

**NOTE:** Please come fragrance and perfume free to your appointment. This protects our patients with chemical sensitivity. We kindly ask that you not eat or drink in our waiting room. We ask that you watch and manage your young children in our waiting room to ensure their good behavior. Thank you for your consideration.

### **CANCELLATION POLICY**

If you do not keep an appointment or cancel without 24 hour notice you will be charged a \$50.00 no show/cancellation fee. Your doctor may request that you prepay with cash or credit card before the next visit can be scheduled.

### **PAYMENT FOR SERVICES**

Payment for physician services, nutritional supplements, diagnostic tests and all other items must be made at the time of the visit unless prior arrangements have been made. We accept cash, checks, MasterCard and Visa. The Center charges a \$15 processing fee for all returned checks. Accounts with balances outstanding 30 days or more will be charged monthly interest of 1.5% of the outstanding balance. Should collection action be required a collection fee of 15% of the outstanding balance will be assessed.

### **INSURANCE: Please note that we do not participate with Medicare or Medicaid**

The Center does not guarantee that your insurance carrier will reimburse all or part of your bill. Not all services are considered covered benefits in all contracts. If we are under contract with an insurance company we will accept their reimbursement rate. If we are not under contract with your insurance company you agree to pay our current fees in full.

**The Center currently accepts and participates with some HMO's and insurance companies. We only participate with primary insurance coverage and cannot submit to secondary coverage insurance plans. We will only submit to a participating secondary insurance when the patient has a completed Medicare denial on file here in the office for the date of service.** We will do all we can to insure payment of the claim within 90 days. If the claim is not paid in 90 days or there is a dispute about the claim, the responsibility will be turned back to you and payment for any unpaid claims will be requested. From that point you will be responsible to see that the insurance company pays the claim. Any duplicate payments will be refunded promptly.

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I hereby authorize the payment of medical benefits directly to my physician. I authorize my physician to release any information acquired in the course of my examination or treatment that may be required; by other medical professionals; by my insurance company and its agents to determine benefits payable for services rendered; and in a collection situation.

I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered on my behalf, as well as late fees or service charges. I understand that giving you my insurance information does not guarantee insurance approval or payment and I accept full responsibility for the payment of services if my medical insurance provider does not pay.

SIGNED \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient, Parent or Guardian's Signature (if patient is a minor)

Rev. 6-8-05

*THESE POLICIES ARE SUBJECT TO CHANGE WITHOUT NOTICE*