Medical Record Number: _____

Patient Information

Legal Name (Last / First / Middle)			Nickname

Social Security Number	Birth Date	☐ Male ☐ Female	Marital Status ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed

Street Address	Zip	City	State

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Preferred Contact Method ☐ Text ☐ Phone ☐ Email ☐ Other

Email *Required	Occupation	Employer

Primary Care Provider	Referring Provider

As part of the American Recovery and Reinvestment Act, healthcare providers are required to obtain the following information. Please check the boxes in section 1-3 that most apply to you.

1. Race (Choose One)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White / Caucasian

2. Ethnicity (Choose One)

☐ Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Declined to Specify

3. Preferred Language (Choose One)

☐ Arabic	☐ English	☐ Hebrew	☐ Korean	☐ Spanish/Castilian	☐ Urdu
☑ Bulgarian	☐ French	☐ Hindi	☐ Polish	☐ Somali	☐ Vietnamese
☐ Chinese	☐ German	☐ Italian	☐ Portuguese	☐ Swahili	☐ Declined to Specify
☐ Central Khmer	☐ Haitian	☐ Japanese	☐ Russian	☐ Thai	

Responsible Party (Policy Holder) / Legal Guardian *if minor, please have parent or legal guardian complete the following.*

☐ Self

Legal Name (Last / First / Middle)	Relationship to Patient ☐ Parent ☐ Other ☐ Spouse	Birth Date

Social Security Number	Address	☐ Check here if same address as above

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

Emergency Contact

Name (Last / First / Middle)	Relationship to Patient

Address

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

Medical Record Number: _____

Patient _____ DOB _____

Insurance

Primary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date
Secondary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date

Medications *include over-the-counter medications and supplements.* ☐ *check box if NO medications.*

Drug Name	Dosage Strength (i.e., mg/mcg)	How many times a day?
1		
2		
3		
4		
5		
6		
7		
8		
Attach additional list if there are more medications		

Allergies ☐ *check box if there are NO medication allergies.*

Drug Name / Drug Class / Food	Reaction
1	
2	
3	
4	

Preferred Local Pharmacy

Name _____ Location _____

Phone _____ Fax _____

Medical History *check all that apply. Describe details of medical conditions in spaces below.*

☐ allergies	☐ cancer: type _____	☐ high blood pressure	☐ migraines
☐ anemia	☐ COPD (Emphysema)	☐ high cholesterol	☐ osteoporosis
☐ angina (heart pain)	☐ Crohn's Disease	☐ HIV / AIDS	☐ prostate enlarged
☐ anxiety	☐ depression	☐ irritable bowel syndrome	☐ seizures
☐ arthritis	☐ diabetes ☐ type 1 ☐ type 2	☐ kidney disease: type _____	☐ stroke
☐ asthma	☐ GERD (acid reflux)	☐ liver disease: type _____	☐ thyroid disease: type _____
☐ atrial fibrillation	☐ heart disease: type _____	☐ MI (heart attack)	☐ ulcer
☐ blood clots	☐ Hepatitis ☐ A ☐ B ☐ C		
☐ Other:			

Medical Record Number: _____

Patient _____ DOB _____

Surgeries *check all that apply. Describe details of surgery in spaces below.*

☐ angioplasty	☐ cataract: ☐ left ☐ right	☐ knee replacement: ☐ left ☐ right
☐ appendectomy	☐ colon surgery: type _____	☐ LASIK
☐ arthroscopy knee: ☐ left ☐ right	☐ c-section	☐ liver biopsy
☐ back surgery: type _____	☐ D&C	☐ mastectomy: ☐ left ☐ right
☐ breast biopsy: ☐ left ☐ right	☐ gallbladder	☐ ovary removed: ☐ left ☐ right
☐ breast implants	☐ gastric bypass	☐ prostate surgery: type _____
☐ breast reduction	☐ groin hernia repair: ☐ left ☐ right	☐ thyroid surgery
☐ CABG (heart vessel bypass)	☐ hip fracture repair: ☐ left ☐ right	☐ tonsillectomy
☐ cardiac pacemaker	☐ hip replacement: ☐ left ☐ right	☐ tubes tied
☐ carpal tunnel: ☐ left ☐ right	☐ hysterectomy	☐ vasectomy

**Items in gray are for females only*

☐ Other:

Family History

Mother	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				
Father	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				
Brother(s)	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				
Sister(s)	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				

Social History *your answers help determine your risk for certain diseases. Responses are confidential.*

Marital Status:
☐ Divorced ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Single ☐ Widowed

Sexual Orientation:
☐ Bisexual ☐ Heterosexual ☐ Homosexual

Transgender Identity, if applicable
☐ Female to Male ☐ Male to Female ☐ Unknown

Do you have any religious or spiritual preferences that would affect your healthcare?

Tobacco Use ☐ Yes ☐ No
Do you... ☐ smoke a pipe ☐ smoke cigarettes ☐ chew tobacco
How many... packs per day? _____
years? _____
If you quit, what year? _____

Do you drink *alcohol?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *illegal drugs?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *caffeine?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Medical Record Number: _____

Patient _____ DOB _____

Women's Health History

Age of first menstrual period?	_____	Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly	
Age of first birth?	_____	Date of last mammogram? _____	Result? _____
Beginning date of last menstrual period?	_____	Date of last pap smear? _____	Result? _____
If you have achieved menopause, what age?	_____	What Year? _____	☐ Natural ☐ Surgical *(choose one)*

Pregnancy History *list the number of each type in the box below.*

Full Term	Premature	C-Section	Vaginal	Live Birth	Ectopic	Miscarriage	Abortion

Preventive Screenings *list dates of the most recent preventive services you've received.*

Test	Test Never Performed	Where Performed?	Last Exam Date	Findings/Results
Bone density	☐			
Blood sugar	☐			
Cholesterol	☐			
Colonoscopy	☐			
Glaucoma	☐			
Hearing	☐			
HIV	☐			
Lung cancer scan (CT of chest)	☐			
Lung scan	☐			
Mammogram	☐			
Medicare wellness visit	☐			
Prostate exam (males only)	☐			
Ultrasound aorta	☐			
Vision examination	☐			

Immunizations *list dates of <u>most recent</u> immunizations or attach record.*

Vaccination	Date	Date	Date
Chicken Pox			
Hepatitis A			
Hepatitis B			
HPV			
Influenza			
Meningococcal			
MMR			
Pneumonia PCV13 (Prevnar 13)			
Pneumonia PPSV23 (Pneumovax)			
Shingles			
Tetanus and Diphtheria (Td)			
Tetanus, Diphtheria, Pertussis (Tdap)			

Pre-appointment Questionnaire Family Health & Wellness Clinic

Name: _____ Date of Birth_____ Today's date: _____

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a **new complaint**, indicate **how long it has been present**, **what it feels like**, **what makes it better or worse**, and **what you are concerned the problem might be**.)

_____

_____

2. Are **you** experiencing any of the following symptoms in relation to your main concern?
(**PLEASE CIRCLE ONLY IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS.)**

Constitutional symptoms: fever, weight loss, extreme fatigue
Eyes: double vision, sudden loss of vision
Ears, nose, mouth and throat: sore throat, runny nose, ear pain
Respiratory: cough, wheezing, shortness of breath
Cardiovascular: chest pain, palpitations
Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools
Genitourinary: irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, sexual issues **When was your last period?** _____
Skin: rash, changing mole
Neurological: headache, persistent weakness or numbness on one side of the body, falling-loss of balance, dizziness
Musculoskeletal: joint pain, muscle weakness
Psychiatric: depression, anxiety, suicidal thoughts
Endocrine: cold or heat intolerance, breast mass
How much water do you drink daily? _____ glasses
Hematologic: unusual bruising or bleeding, enlarged lymph nodes
Allergic: Hay fever

3. Has anything **NEW** come up in your family history? (For example, have any of your blood relatives recently developed a new illness?) _____

4. Have you taken any **NEW** drugs since your last visit? Any **drug allergies**?
_____

5. Are you taking any **OVER THE COUNTER** medications/or supplements? _____

6. Do you exercise? _____How often? _____

7. How much weight have you **gained** or **lost** this past year? _____

8. Over the last year, how many times have you fallen? **NONE** or _____times. If you have fallen, did you receive any injuries? _____

9. What is your preferred pharmacy? Retail (In town) _____
Name/Location/Phone number

***Compare costs and save with www.oklahomadrugcard.com**

Mail order_____
Name/Location / Phone number

Family Health& Wellness Clinic

PATIENT AUTHORIZATION FOR TREATMENT AND FINANCIAL STATEMENT

Authorization for Treatment: By virtue of my signature, I authorize Family Health and Wellness Clinic(FHAW), and any of its employees or other authorized personnel or agents, to provide general healthcare services to me.

Financial Statement: Payment is due immediately upon the provision of services unless a previous arrangement has been made. New patients are required to pay total charges, the full amount of their copayment, or a minimum of 20% at the time if FHAW files the claim for benefits with the primary insurance company. Failure to pay the co-payment at the time of service can result in loss of healthcare benefits and/or dismissal from FHAW. At FHAW, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you may be liable.

I understand that **if** I am unwilling to authorize FHAW to release information for purposes of obtaining reimbursement or determining coverage may result in FHAW requiring me to pay in full on a cash basis at the time services are rendered. I accept that I am bound by FHAW'S payment policies, as articulated above.

Any patient having outstanding balance on their account which is unpaid for **60 days** or more will be required to pay for any charges incurred at the time of service and to make arrangements for the payment of any outstanding balance due on the account.

Any patient having an outstanding balance on their account that is unpaid for **90 days** or more will have their account turned over for collection and any future services will be made available only on an immediate cash basis. FHAW may, at its discretion, choose to work with those patients who incur accounts having a large dollar balance, by creating a payment schedule or other appropriate arrangement. In the event of my default I agree to pay all costs of collection incurred by FHAW, including but not limited to my attorney fees.

By virtue of my signature below. I hereby acknowledge that I have read the above information and that I agree to be bound by all of FHAW payment policies.

Assignment of Benefits: I hereby authorize payment of any benefits for services rendered by FHAW be made directly to FHAW. I authorize FHAW to refund any overpaid insurance benefits where the overpayment is subject to coordination of benefits.

Patient Acknowledgement: By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, and that I have been given adequate opportunity to ask questions about the same.

Signature: By patient's signature below, Patient states the patient is **18 years old of age or over** and is legally capacitated to give consent to treatment and to authorize release of the above information.

Patient Signature _____ Date _____

Patient's Printed Name _____ Date of Birth _____

By signature of a parent or legal guardian below, such individual represents that Patient is **under age 18**, a minor, or has a court appointed guardian.

Signature of Parent/Guardian_____ Date: _____

Relationship to Patient_____

Family Health& Wellness Clinic

Susan Willard, D.O.

CREDIT CARD ON FILE POLICY

At Family Health and Wellness, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you may be liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Family Health and Wellness Clinic to charge the portion of my bill that is my financial responsibility to the following credit or debit card not to exceed $150.00:

☐**Amex** ☐**Visa** ☐**MasterCard** ☐**Discover**

Credit Card Number _____

Expiration Date _____/_____/ _____

Cardholder Name _____

Signature _____

Billing Address _____

City_____**State**_____**Zip** _____

I (we), the undersigned, authorize and request **Family Health and Wellness Clinic** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Family Health and Wellness Clinic.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to **Family Health and Wellness Clinic** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____/_____/ _____

P - (918) 740-4630 • F - (918) 289-0091

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPPA), I agree *Family Health & Wellness Clinic* and its duly authorized employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends and/or any other individuals that I may indicate below who may contact *Family Health & Wellness Clinic* on my behalf.

List the name of individual(s) and relationship: PLEASE PRINT
Circle next to the name to identify the type of information to be disclosed

Medical Billing _____

Medical Billing _____

Medical Billing _____

I understand:

- At any time, I may add or remove individuals from this list by notifying Family Health & Wellness Clinic my desire to do so. I understand that until I notify Family Health & Wellness Clinic of requested changes to this list, Family Health and Wellness may rely on this list and disclose information the individuals listed above.
- Information disclosed to the individuals identified above may be subject to disclosure by the recipient and no longer protected by federal law.

* I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but not limited to, diseases such as, hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (AIDS). My medical information may indicate that I have or have been treated for psychological or psychiatric condition or substance abuse.

_____Date _____
Signature of Patient

_____Date_____
Signature of Patient of Personal Representative

_____
Description of Representatives authority to act for this patient

Family Health& Wellness Clinic

PATIENT CANCELLATION AND NO SHOW POLICY

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. If you need to reschedule or cancel an appointment, we require notice by **noon the previous business day**. Please call the office, 918-740-4630.

"No shows" or last minute cancellations leave empty appointment times that could be filled by other patients waiting to receive medical care. For that reason, clients that do not honor their appointments will be charged a cancellation fee:

LATER THAN NOON THE PREVIOUS BUSINESS DAY AND NO SHOW: $40.00

We realize that on a rare occasion, emergencies may arise and we will address these situations with you at that time. We thank you for working with us to ensure services are provided to you and others, in the best way possible. _____

Acknowledgement of Cancellation and No Show Policy

Name: _____

Signature: _____

Date: _____

Family Health and Wellness Clinic
Susan Willard, D.O.
6532 East 71st Street, Suite 150
Tulsa, Oklahoma 74133

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

****

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

  _____
  _____
  _____
  _____

Family Health and Wellness Clinic
Susan Willard, D.O.
6532 East 71st Street, Suite 150
Tulsa, Oklahoma 74133

Authorization for use/Disclosure of Protected Health Information

I, _____ hereby authorize release of my medical records as described below to Family Health and Wellness Clinic (Dr. Susan Willard D.O.)

TYPE OF INFORMATION TO BE DISCLOSED:

	Entire Medical Record		**Radiology Reports**
	Immunization Record		**Discharge Summary**
	Laboratory Test Reports		**Medication Record**

In addition, I authorize that this will include health information relating to (check if applicable);

	Communicable diseases (including HIV and AIDS)
	Drug/Alcohol Abuse
	Mental Health Records

COVERED DATES OF SERVICE:

This authorization includes the period of health care from:
_____to _____

Expiration:
This authorization will be in effect, unless revoked in writing, for (1) year from today's date or until the date written here:_____

PATIENT INFORMATION (PLEASE PRINT):
Name: _____Date of birth: _____
Social Security Number: _____

RELEASE MY MEDICAL RECORDS FROM:
Health Care Provider/Entity: _____
Telephone: _____Fax:_____

TO: **Family Health and Wellness Clinic**
Dr. Susan Willard D.O.
6532 East 71st Street, Suite 150
Tulsa, Oklahoma 74133
Phone: 918-740-4630 **Fax: 918-289-0091**

Patient/Guardian Signature: _____Today's Date_____

Relationship to patient(if applicable):

	Parent or Guardian of minor		**Power of Attorney**
	Court appointed guardian		**Executor of descendent's estate**