Norman Clinic Inc.

Patient Information

Name____ Date of Birth___________

Mailing Address____

City_________________________ State_____________ Zip __________________

SSN#_______________________ Marital Status__________________ Student Y / N

Home Phone__________________________ Cell Phone______________________

Employer_____________________________ Work Phone_____________________

Email Address____

Pharmacy ____

Race ________________________ Primary Language__________________________
Hispanic or Latino Yes_______ No________

Emergency Contact Info

Name____________________________ Relation____________ Phone_______________

Insurance

Primary Insurance____
ID____ Group______________________
Name of Insured___________________________________ Date of Birth______________
Insured SSN___________________________ Relation to Patient ___________________

Secondary Insurance ____
ID ____ Group_____________________
Name of Insured_____________________________________ Date of Birth_____________
Insured SSN___________________________ Relation to Patient____________________

*****Will today's claim be billed to workers compensation Y / N**

*****<u>If we are sending today's claim to Medicare, please answer the following</u>:**
Is this Medicare Disability Y / N If yes, are there more than 100 employees Y / N
Please tell us if <u>YOU</u> or your <u>SPOUSE</u> is the insured party ___________________
Is the insured currently working Y /N If yes, are there more than 20 employees Y / N

Signature____ Date________________

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name Date of Birth

Address

Area Code & Telephone Number City State Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Clinic, Inc to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Clinic, Inc as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations Authorized to Receive My Information:

(Name, Address, Phone & Fax) Relationship Purpose

____

____

____

____

Information to be shared

1. Check one or more boxes below.

- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
- ☐ Psychotherapy Notes
- ☐ Mental Health Records

☐ Pathology Report	☐ History and Physical	☐ Operation Report(s)
☐ Progress Notes	☐ Consultation Report(s)	☐ Discharge Summary
☐ EKG Report(s)	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ Physician's Orders	☐ Radiology Films	☐ Alcohol or Drug Abuse Records
☐ Other		

2. Covering Services Between _____________ and _____________ (Insert either date(s) or "all.")

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (**must choose one**):

☐ 3 years after last office encounter ☐ Other (insert date or event): ______________________

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

4. I understand Norman Clinic, Inc, as a member of Oklahoma Physician Health Exchange (OPHX), may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.

5. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative) Date

____

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

____

Physician / Clinic Address: Norman Clinic
950 North Porter Avenue
Norman, Oklahoma 73071

Norman Clinic Questionnaire

Name:____ Age:____________ Date of Birth: ______________

Who referred you? _____________________________

Present and Past Medical History: Check any present or past conditions

____Abnormal Pap Smear	____High Cholesterol	____IBS
____Allergies	____Gallstones	____Colon Polyps
____Anemia	____Heart Disease	____Acid Reflux
____Anxiety	____Chronic Pain	____PMS
____Asthma	____Restless Leg Syndrome	____Migraines
____Arthritis,Type___________	____Kidney Disease	____Pneumonia
____Back Pain	____High Blood Pressure	____Recurrent UTIs
____Cancer,Type____________	____HPV	____Blood Clot
____COPD	____Infertility	____Stomach Ulcer
____Depression	____Irregular Periods	____Stroke
____Diabetes	____Kidney Stones	____Thyroid Disorder

Surgeries or Hospitalizations: List date and reason please.

1. _____________________________________
2. _____________________________________
3. _____________________________________
4. _____________________________________
5. _____________________________________
6. ____
7. ____
8. ____
9. ____
10. _______________________________________

Current Medications and OTC / Supplements:

1. _____________________________________
2. _____________________________________
3. _____________________________________
4. _____________________________________
5. _____________________________________
6. _____________________________________
7. _____________________________________
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____

Drug Allergies:

1. _____________________________________ Reaction ____
2. _____________________________________ Reaction ____
3. _____________________________________ Reaction ____

Menstrual History:

Age of First Period _______ Last Menstrual Period ___________ Last Pap ____________
Number of Pregnancies ____________ Live Births ______ Miscarriages ______ Abortions ______
Are you currently using contraception? ____________________ What type? ____________________

Social History:

1. Check One: ____Married ____Single ____Divorced ____Other

	Yes	No
2. Do you have children?	____	____
If yes, how many? _____		
3. What is your occupation? ____		
4. Are you now or have you ever been a smoker?	____	____
5. Do you use other tobacco products?	____	____
6. Do you drink alcohol?	____	____
7. Are you now using or have you ever used illegal drugs?	____	____

Health Maintenance:

1. Do you exercise regularly?	____	____
How often and what type? ____		
2. Do you follow a low-fat diet?	____	____
3. Do you wear a seat belt?	____	____
4. Have you ever been a victim of physical or sexual abuse?	____	____
5. Women, do you practice Self Breast Examination?	____	____

Please recall the date of your last vaccination or test, as applicable:

Mammogram _____________
Prostate Exam _____________
Cholesterol _____________ Result ________________________
Colonoscopy _____________
Eye Exam _____________
Dental Exam _____________
Tetanus _____________
Shingles Vaccine _____________
Pneumovax _____________
Flu Shot _____________
Hepatitis B series _____________
Bone Densitometry _____________
HPV Vaccine _____________

Family History: Please indicate which family member, and at what age, have any of the following

Arthritis _______________________________
Depression/Anxiety_______________________
Blood Disorders _________________________
Cancer ________________________________
Diabetes _______________________________
Heart Disease ______________________________
High Blood Pressure __________________________
Stroke _______________________________________
Other _______________________________________
Other _______________________________________

Are there other issues you wish to discuss with your physician?

____

____

____

Do you have a health care proxy (living will)? ____