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): _____

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI con't

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 New Patient Questionnaire

Name:_____ **DOB:**_____ **Date:**_____

Reason for visit/When did the problem begin?_____

_____

PLEASE LIST ALL MEDICATIONS including creams, inhalers, herbal supplements and over the counter

Medication	Dose	Frequency
Over the Counter Medications		
Vitamins		

PLEASE LIST ALL DRUG AND NON-DRUG ALLERGIES

Allergy	Type of Reaction or Intolerance

Do you have a living will? O Yes O No If yes, please provide a copy

Norman Clinic New Patient Questionnaire

«FirstName» «LastName» **«DOB»** **June 5, 2012**

PAST MEDICAL HISTORY (Fill Circle Completely)

O	Allergic Rhinitis	O	Anxiety	O	Arthritis
O	Asthma	O	Atrial Fibrillation	O	Enlarged Prostate
O	Colon Polyp	O	COPD	O	Depression
O	Diabetes	O	Diverticulitis	O	Emphysema
O	Esophageal Reflux	O	Gout	O	Heart Failure
O	Hepatitis B	O	Hepatitis C	O	High Blood Pressure
O	High Cholesterol	O	Irritable Bowel Syndrome	O	Kidney Stones
O	Heart Attack	O	Osteoporosis	O	Pneumonia
O	Renal Failure	O	Rheumatic Fever	O	Seizures
O	Shingles	O	Sleep Apnea	O	Stroke
O	Thyroid Disease	O	Tuberculosis	O	Ulcers
O	UTI	O	Cancer_____		

O Other (not listed above)_____

SURGICAL HISTORY (Fill Circle Completely)

O	Appendectomy	O	Bladder Lift	O	Cataract Removal
O	Gall Bladder	O	D&C	O	Heart Bypass Surgery
O	Hip Replacement	O	Hysterectomy	O	Knee Replacement
O	Prostate Surgery	O	Shoulder Replacement	O	Tonsillectomy
O	Tubal Ligation	O	Other (not listed above) _____		

Please list any accidents - Include fractures, spinal injuries, concussions, etc and date of occurrence

_____

_____

Have you ever had a blood transfusion? If so, Date _____ Type _____ Reason _____

Have you ever had any of the following vaccines?

Pneumonia	O Yes	O No	Date _____
Shingles	O Yes	O No	Date _____
Tetanus	O Yes	O No	Date _____

Norman Clinic New Patient Questionnaire

«FirstName» «LastName» **«DOB»** **June 5, 2012**

FAMILY HISTORY (Fill Circle Completely)

Father	Mother	Siblings
O Diabetes	O Diabetes	O Diabetes
O Hypertension	O Hypertension	O Hypertension
O High Cholesterol	O High Cholesterol	O High Cholesterol
O Heart Attack	O Heart Attack	O Heart Attack
O Cancer	O Cancer	O Cancer

Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
O Diabetes	O Diabetes	O Diabetes	O Diabetes
O Hypertension	O Hypertension	O Hypertension	O Hypertension
O High Cholesterol	O High Cholesterol	O High Cholesterol	O High Cholesterol
O Heart Attack	O Heart Attack	O Heart Attack	O Heart Attack
O Cancer	O Cancer	O Cancer	O Cancer

SOCIAL HISTORY (Fill Circle Completely)

Alcohol: O Yes O No If yes what type and how much per week?_____

Smoking: O Yes O No If yes how many years?____ How many packs per day?____

Exercise: O Yes O No If yes what type? _____ How often? _____

Caffeine: O Yes O No If yes how much? _____

Recreational drug use O Yes O No If yes what type?_____

Marital Status: O Married O Single O Divorced O Widowed O Other

REVIEW OF SYSTEMS (Fill Circle Completely)

CARDIOLOGY

Murmurs O Yes O No

Irregular heart beat O Yes O No

Chest pain with exercise O Yes O No

Shortness of breath at night O Yes O No

Swelling of ankles O Yes O No

Sleeps with multiple pillows O Yes O No

CONSTITUTIONAL

Fatigue O Yes O No

Night sweats O Yes O No

Change in Weight O Yes O No

Change in Appetite O Yes O No

REVIEW OF SYSTEMS (Fill Circle Completely)

DERMATOLOGY

Rash	O Yes	O No
New/changing skin lesion	O Yes	O No
Suspicious lesions	O Yes	O No
Suspicious Mole	O Yes	O No

ENDOCRINOLOGY

Cold intolerance	O Yes	O No
Heat intolerance	O Yes	O No
Excessive sweating	O Yes	O No
Excessive thirst	O Yes	O No

ENT

Nose Bleeds	O Yes	O No
Hearing loss	O Yes	O No
Cough	O Yes	O No
Hoarseness	O Yes	O No
Snoring	O Yes	O No

GASTROENTEROLOGY

Loss of appetite	O Yes	O No
Abdominal pain	O Yes	O No
Bloating	O Yes	O No
Indigestion	O Yes	O No
Vomiting	O Yes	O No
Blood in stool	O Yes	O No
Diarrhea	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Hemorrhoids	O Yes	O No
Difficulty swallowing	O Yes	O No

MUSCULOSKELETAL

Muscle aches	O Yes	O No
Bone pain	O Yes	O No
Joint stiffness	O Yes	O No
Joint swelling	O Yes	O No
Leg cramps	O Yes	O No
Joint pain	O Yes	O No
Back pain	O Yes	O No
Nighttime burning of feet	O Yes	O No

NEUROLOGY

Paralysis	O Yes	O No
Seizures	O Yes	O No
Tremor	O Yes	O No

PSYCHOLOGY

Depression	O Yes	O No
Sleep disturbances	O Yes	O No
Anxiety	O Yes	O No
Memory loss	O Yes	O No
Insomnia	O Yes	O No

RESPIRATORY

Shortness of breath	O Yes	O No
Wheezing	O Yes	O No
Blood-tinged sputum	O Yes	O No

UROLOGY

Previous Bladder Infections	O Yes	O No
Blood in urine	O Yes	O No
Pain with urination	O Yes	O No
Urinary frequency	O Yes	O No
Frequent Nighttime Urination	O Yes	O No