Patient Registration

Reason for today's visit: _____

If this is an injury, is it work related? YES NO

Primary Care Provider: _____

Mailing Address:_____ **City:** _____ **State**_____ **Zip:**_____

Phone Number Cell:_____ **Work:** _____ **Home:**_____

Patient Information

Last Name:_____**First Name**_____**Middle initial**____

Mailing Address:_____ **City:** _____ **State**_____ **Zip:**_____

Phone Number Cell:_____ **Work:** _____ **Home:**_____

Date of Birth___/____/____ **Gender:** M F **Social Security #** _____

Marital Status: _____ **Race:**_____ **Ethnicity:**_____

Preferred Language_____

Email: _____

Patient Employer Information:

Name of Company:_____ **Phone #:**_____

Street Address:_____ **City:**_____ **State:**____ **Zip:**_____

Responsible Party Information (if different from above):

Last Name:_____**First Name**_____**Middle initial**____

Mailing Address:_____ **City:** _____ **State**_____ **Zip:**_____

Phone Number Cell:_____ **Work:** _____ **Home:**_____

Date of Birth___/____/____ **Gender:** M F **Social Security #** _____

Relationship to Patient: _____

Insurance Policy Holder Information:

Primary: Insurance:_____ **Subscriber ID:**_____ **Group #:**_____

Last Name:_____ **First Name**_____ **Middle initial**____

Mailing Address:_____ **City:** _____ **State**_____ **Zip:**_____

Phone Number Cell:_____ **Work:** _____ **Home:**_____

Date of Birth___/____/____ **Gender:** M F **Social Security #** _____

Relationship to Patient: _____

Secondary: Insurance:_____ **Subscriber ID:**_____ **Group #:**_____

Last Name:_____ **First Name**_____ **Middle initial**____

Mailing Address:_____ **City:** _____ **State**_____ **Zip:**_____

Phone Number Cell:_____ **Work:** _____ **Home:**_____

Date of Birth___/____/____ **Gender:** M F **Social Security #** _____

Relationship to Patient: _____

Emergency Contact:

Name: _____ **Relationship to Patient:**_____

Phone #: _____ **Local Pharmacy:** _____

I certify that the information provided is complete and accurate to the best of my knowledge.

_____

Signature of Patient or Patient Representative **Date**

CARRUS CARE
CLINIC OF BRISTOW

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, co-insurance, or non-covered services.

-Co-payments are due at the time of service.

-If my plan requires a referral, I must obtain it prior to my visit.

- In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.

- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to CARRUS CARE PHYSICIAN GROUP on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize CARRUS CARE PHYSICIAN GROUP to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral; to another medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in CARRUS CARE PHYSICIAN GROUP. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

Signature of Patient, Authorized Representative, or Responsible Party **Date**

Print Name of Patient, Authorized Representative, or Responsible Party **Date**

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or is there any chance you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

_____ _____

Date Signature of Person Completing Health History

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

_____ _____ _____

Date Exceptions or changes Patient's Signature

_____ _____ _____

Date Exceptions or changes Patient's Signature

KNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

You may refuse to sign this acknowledgment

Patient Name:_____ **DOB:**_____

I have received a copy of Carrus Care Clinic of Bristow notice of privacy practices. I hereby authorize the following person or persons to receive medical information regarding my care.

Authorization list

Name	Relationship

_____

(Signature of Patient)

_____

(Date)

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

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize Carrus Care Clinic of Bristow
Name of Person/Organization Disclosing PHI

to release the following information to Patient or Patient's Physician
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between_____ and _____

☒ Other: imaging disc and/or reports

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☒ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

CARRUS CARE
CLINIC OF BRISTOW

OUT OF NETWORK INSURANCE

PATIENT RESPONSIBILITY FORM

I have been informed that my insurance is out of network with the provider I am seeing today, I agree to be seen anyway. I understand I will be responsible for any amounts my insurance does not pay.

_____

Patient name

_____

Date of Service

CARRUS CARE
CLINIC OF BRISTOW

AUTHORIZED GUARDIAN LIST

I hereby authorize those listed below to bring and consent to treatment plan for

(Pediatric Patient Name) _____ Patient DOB: _____

in my absence.

Authorized List

Name	**Relationship to Patient**
Name	**Relationship to Patient**
Name	**Relationship to Patient**
Name	**Relationship to Patient**
Name	**Relationship to Patient**

Patient name	**Date**
Legal Guardian Signature	**Date**
Print Name of Legal Guardian	**Date**