**Patient Data Sheet**

Name: Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ Age:\_\_\_\_\_\_ SSN:\_\_\_\_\_ / \_\_\_\_\_ /\_\_\_\_\_ **Marital Status:** S / M / W / D / Sep.

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

**\*Race:** **(Please Circle)** American Indian / Asian / Black / Native Hawaiian / Other Pacific Islander / White / More than one race / Refuse to Report

**\*Ethnicity:** **(Please Circle)** Hispanic or Latino / NOT Hispanic or Latino / Refuse

**\*Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Have Living Will: (Please Circle)** Yes or NO

Home Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How May We Contact You:** Home\_\_\_\_\_Cell\_\_\_\_\_Work\_\_\_\_\_Voicemail\_\_\_\_\_Text Message\_\_\_\_Email\_\_\_\_

**May we leave test results on any of the following:** Home\_\_\_Cell\_\_\_ Work\_\_\_Voicemail\_\_\_ Text Message\_\_Email\_\_\_

Spouse’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Cell Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Work Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:**( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guarantor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance/Guarantor Information**

Primary Insurance Coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder/Guarantor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Nearest Relative / Friend (not living with you) to notify in case of an emergency**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

Another Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician Information**

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:( \_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Review of Systems**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_ /\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

**I AM HERE TODAY FOR:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\*\*\*Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any of the symptoms below that pertain to your CURRENT CONDITION:**

For Patients 65 and Older:
 \* Have you had a fall with injury in the past year?
 **Yes or No**

\* Have you had 2 or more falls over the past year?
 **Yes or No**

**GENERAL:** Fatigue, Fever, Weight Gain , Weight Loss

**SKIN:** Acne, Changes in Pigmentation, Jaundice , Hair Loss, Itching,

Psoriasis, Rashes, Suspicious Skin Lesions

**HEENT:** Chronic-Sinusitis, Dizziness, Double-Vision, Earaches, Ear-Discharge,

Headaches, Excessive-Tearing, Hearing-Loss, Nasal-Discharge, Nosebleeds,

 Oral Ulcers, Ringing-in-the-Ears, Trauma, Trouble-Swallowing, Visual-Changes

**NECK:** Goiter, Swelling, Stiffness, Tenderness

**BREAST:** Lumps, Nipple-Discharge, Pain, Tenderness

 **Monthly Self Breast Exam? Yes / No**

**RESP:**  Asthma, Cough, Coughing-up-of-Blood, Chronic-Bronchitis, Pneumonia,

Shortness-of-Breath, **Do you Smoke: Yes / No
 IF YES How Much:\_\_\_\_\_\_\_\_\_\_**

 **CV:** Chest-pain, Edema, Exercise-Intolerance, Heart-Failure, Heart Murmur,
 Sudden-Shortness-of-Breath-While-Sleeping-or-Laying-Down-Flat, Palpitations

**GI:** Abdominal-Pain, Appetite, Black-Tarry-Stools, Blood-in-Stools, Change-in-Stool-Size, Constipation, Diarrhea, Diverticular-Disease, Poor-Appetite, Nausea, Vomiting, Vomiting-Blood

**URINARY:** Burning, Blood-in-Urine Frequency, Incontinence, Leaking-of-Urine-with-Cough-or-Sneeze, Urgency, Overactive-Bladder. Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REPROD:** Last Menstrual-Period\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_. Abnormal-Bleeding , Itching , Pain-with-Intercourse, Painful-Periods, Pelvic-Pain, Vaginal-Discharge, Vaginal-Pressure, Contraception:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MS:** Gout , Joint-Pain, Muscular-Weakness, Swelling

**HEM:**  Abnormal-Bruising, Anemia, Bleeding-Disorders, Blood-Transfusions, Hepatitis, HIV

**NEURO-PSYCH:** Anxiety, Depression, Difficulty-with-Speech, Fainting, Gait Disturbance, Mood-Swings, Paralysis, Seizures, Psychiatric-Care, Mental-Status-Changes, Thoughts-of-Suicide,

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**OTHER SYMPTOMS:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Dates Completed |
| Colonoscopy |  |  |  |
| Mammogram |  |  |  |
| Pap Smear |  |  |  |
| Bone Density |  |  |  |

**Recent Immunizations:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Dates Completed |
|  HPV |  |  |  |
|  Influenza (Flu) |  |  |  |
|  Pneumonia |  |  |  |

**Review of Systems (part 2)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all Current Medications (***including all Vitamins, or Herbal***)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Times per Day | Illness / Problem |
|  |  |  |  |
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Please list any **Drug Allergies**. Please include specific reaction:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication: |  | Reaction: |  |
| Medication: |  | Reaction: |  |
| Medication: |  | Reaction: |  |

Please list any **Allergies ( Food, Environmental, or other)**:

|  |  |  |
| --- | --- | --- |
| - | Reaction: |  |
| - | Reaction: |  |
| - | Reaction: |  |
| If you have NONE please check mark box  |

Please indicate any changes in your **Personal**, **Family**, and or **Social** history:

|  |  |  |
| --- | --- | --- |
| A)Have you had any recent: * Hospitalizations
* Illness
* Surgeries
* Traveling
* No Change

\*Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (B) Any changes in Family History* Health Status/Cause
* death of parents siblings, &/or children (specific diseases related)
* No Change

\*Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (C) Social* Alcohol / Drug/Tobacco Use
* Current Employment
* Marital Status
* Sexual History
* No Change

\*Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please identify any **Physicians** that you have been recently seen by:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date Seen: | Physician: | Specialty: | City: | Hospital Affiliation: |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Any other problems you wish Dr. Smith to know about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*Please complete the survey below based on your **Current** **Pain Level**:

**Pain Location:** Place an **X** on the diagram on every area you are experiencing pain.

**Pain Radiation:** Draw an arrow in the direction the pain is radiating from the **X**
marked on the diagram. If it’s NOT radiating then, go to the next step.

**Pain Quality:** Please **Check Mark** all that apply to your pain.

|  |  |  |
| --- | --- | --- |
| Sharp \_\_\_ | Dull \_\_\_ | Aching \_\_\_ |
| Burning \_\_\_ | Shooting \_\_\_ | Stinging \_\_\_ |
| Stabbing \_\_\_ | Throbbing \_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Pain Scale:** Enter a number from 1-10\_\_\_\_\_\_\_\_(Please refer to illustration below)



**Pain Progression:** Circle one below:

 Unchanged Improved Worsening Resolved

**Onset of Pain:** When did the pain start? Date and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain is Relieved By:** Check all that apply:

|  |  |  |
| --- | --- | --- |
| Rest \_\_\_ | Ibuprofen, Advil \_\_\_ | Herbal \_\_\_ |
| Heat \_\_\_ | Tylenol \_\_\_ | Lortab, Demerol \_\_\_ |
| Meditation \_\_\_ | Pamprin, Midol \_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Pain is Bothered By:** Check all that apply:

|  |  |  |
| --- | --- | --- |
| Standing \_\_\_ | Physical Activity \_\_\_ | Constipation \_\_\_ |
| Sitting \_\_\_ | Intercourse \_\_\_ | Urinating \_\_\_ |
| Walking \_\_\_ | Menses \_\_\_ | Bowel Movement \_\_\_ |

**Patient History (part 1)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO you **NOW** have or **Have you ever had** in your life, any of the following DIAGNOSES. Please Circle **Y or N**.

 Also, please tell us if you have a FAMILY HISTORY of any of the same Diagnoses and who that was in your family.

  **Personal Family**

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Nurse Initials:

 **Diagnoses: History History Which Family Member**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PLEASE CIRCLE** |  **YES** |  **NO** |  |  **YES** | **NO** |  |
| Alcohol Use |  Y |  N |  |  Y  |  N |  |
| Asthma |  Y |  N |  |  Y  |  N |  |
| Blood-clots in Leg / Lung |  Y |  N |  |  Y  |  N |  |
| Blood Transfusion |  Y |  N |  |  Y  |  N |  |
| Breast Cancer |  Y |  N |  |  Y  |  N |  |
| Cancer |  Y |  N |  |  Y  |  N |  |
| Diabetes |  Y |  N |  |  Y  |  N |  |
| Gonorrhea (GC “Clap”) |  Y |  N |  |  Y  |  N |  |
| Growths |  Y |  N |  |  Y  |  N |  |
| Heart Disease |  Y |  N |  |  Y  |  N |  |
| Herpes |  Y |  N |  |  Y  |  N |  |
| Hepatitis / Liver Disease |  Y |  N |  |  Y  |  N |  |
| High Blood Pressure |  Y |  N |  |  Y  |  N |  |
| Kidney Disease |  Y |  N |  |  Y  |  N |  |
| Mental Illness |  Y |  N |  |  Y  |  N |  |
| Neurologic / Epilepsy |  Y |  N |  |  Y  |  N |  |
| Pneumonia |  Y |  N |  |  Y  |  N |  |
| Psychological |  Y |  N |  |  Y  |  N |  |
| Rheumatic Fever |  Y |  N |  |  Y  |  N |  |
| Scarlet Fever |  Y |  N |  |  Y  |  N |  |
| Syphilis |  Y |  N |  |  Y  |  N |  |
| Thyroid Disease |  Y |  N |  |  Y  |  N |  |
| Tuberculosis |  Y |  N |  |  Y  |  N |  |
| Tumors |  Y |  N |  |  Y  |  N |  |
| Urinary Infection |  Y |  N |  |  Y  |  N |  |
| Varicosities / Phlebitis |  Y |  N |  |  Y  |  N |  |
| Other V.D. (S.T.D.) |  Y |  N |  |  Y  |  N |  |
| Other: |  Y |  N |  |  Y  |  N |  |

 **Past Treatments: YES NO Comments/Dates & Responses for Treatments**

|  |  |  |  |
| --- | --- | --- | --- |
| Chemo Therapy |  Y |  N |  |
| Radiation Therapy |  Y |  N |  |
| Serious Accident |  Y |  N |  |
| Hospitalizations  |  Y |  N |  |
| **Operations** (Please List) |  Y |  N |  |
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**Patient History (part 2)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Social History:** |  |  |  |  |
|  | Currently Using:  **(Please Circle)**  | **Amount Each Day** | **# Years of Use** | **Start Date** | **Quit Date** |
| **Exercise / Fitness** |  Yes - NO - Sometimes |  |  |  |  |
| **Alcohol Use** |  Yes - NO - Sometimes |  |  |  |  |
| **Tobacco Use** |  Yes - NO - Sometimes |  |  |  |  |
| **Illicit Drug Use** |  Yes - NO - Sometimes |  |  |  |  |

|  |
| --- |
| **Gynecologic Testing:** |
| Date of last Pap Smear: |  |
| Date(s) of any abnormal Pap(s): |
| Date of Hepatitis B Shot: |  |
| Monthly Self Breast Exam | Yes - No |
|  |  |
|  |  |
| **Cervical & Vaginal Cancer High Risk Factors** |
| Sexually active before 16  | Yes - No |
| Currently sexually active | Yes - No |
| # of Partners in past 12 months |  |
| Have had 5 partners or more | Yes - No |
| History of STD including HIV | Yes - No |
| Exposed to Diethylstilbestrol in utero | Yes - No |
| Cervical CA in the last 3 years? | Yes - No |

|  |
| --- |
| **Menstrual History:** (If you still have your uterus) |
| **Age** of first Cycle: |  |
| Cycle (monthly, irregular): |  |
| Duration (# of days): |  |
| Flow (1-10 Scale): |  |
| Pain (1-10 Scale): |  |
| Quality (sharp, cramps): |  |
|  |  |
| **Recent Menstrual Cycle:**  |  |
| **Date** of Last Menstrual Cycle: |  |
| Duration ( # of days): |  |
| Cycle (monthly or irregular): |  |
| **If Irregular - Date** of prev. cycle: |  |
| Do you bleed between cycles: |  |
| Do you bleed w/ intercourse: |  |
|  |  |
| Are you Pregnant:  |  Yes - No |
| **Age** of Menopause: |  |
| **Had a Hysterectomy:**  |  Yes - No |
|  |  |
| **Obstetrical History** (If applicable): |
| Total number (**#**) of Pregnancies: |  |
| **#** of **Full Term** Pregnancies: |  |
| **#** of **Premature** Pregnancies  |  |
| **#** of **Living** Children |  |
| **#** of Abortions |  |
| Age of Youngest Child |  |
| Age of Oldest Child |  |
| Complications w/ any deliveries  |  |
| Problem with Infertility: |  |
|  |  |
| **Current Contraceptive Usage** (Please Circle): |
| Condoms, Diaphragm, Foam , IUD, Implant, Patch, Pills, Ring, Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Sterilization:** Hysterectomy, Tubal-Ligation |

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**HIPAA**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Benefits to Physician***

I (the patient) hereby authorize payments to be made directly to the physician of the surgical and/ or medical benefits. Please note that if you are not the Primary Insured, i.e., your coverage is through a spouse or parent, that person MUST sign this form with you. **I also understand that I / We are financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney’s fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be a valid as the original.**

***Consent for Treatment***

I (the patient) consent to the treatment indicated on my examination for, including the use of anesthetics, biopsies, sedatives, colposcopy, x-ray, lab, injections, or pathology consultations as may be deemed necessary by the physician. These treatments and tests will billed separately from any office visit charges and THEY WILL **NOT** BE BILLED BY OUR OFFICE. You will be responsible to pay those bills to those entities.

***Release of Confidential Information***

I (the patient) hereby authorize the release of information for insurance claims purposes, consulting physicians, and hospital medical records. Photostat of the above is as valid as the original. I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I understand there is a standard photocopying charge of a $1.00 for the first page and $0.50 for each additional sheet that may apply to the requesting party only.

**My signature below acknowledges I have completely and thoroughly read understand the above, Benefits to Physician, Consent for Treatment, and Release of Confidential Information and intend to be legally bound hereby.**

**Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Spouse / Primary Insured’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse / Primary Insured’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_/\_\_\_/\_\_\_

Please indicated below the following **Individuals / Organizations** you would like your medical information released to:

|  |  |
| --- | --- |
| Name: | Contact Number: |
|  |  |
|  |  |
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USE & DISCLOSURE of the Health Information

For Treatment, Payment, or Healthcare Operations.

I understand that as part of my health and medical care, Dr. Jeffrey Smith originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment. I further understand that this information serves as:

* A basis for planning my care and treatment
* A means of communication among the health professionals who contribute to my care
* A source of information for applying my diagnosis and treatment information to my bill
* A means for a third-party payer to verify that services were billed as actually provided
* And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Dr. Jeffrey Smith reserves the right to change the notice and mail a copy to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Smith is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you that the information authorized for release may include records, which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I (the Patient) request the following **RESTRICTIONS** to the use &/ or disclosure of my health information:

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

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Office Appointments

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to maintain our continuing optimal physician patient relationship, it is very important that you keep your scheduled appointments when they are made per Dr. Smith’s recommendations. We do understand that sometimes things happen which cause you to reschedule or cancel your appointment. However we do require a 48-hour notice on all **cancellations** in order to make sure that all patients who need to be seen can be scheduled. Effectively immediately, we are implementing a **$25.00** service charge for all patients who fail to show up for their appointments without notifying the office. We are also implementing a **$25.00** service charge for all patients that arrive 20 minutes or more late to their scheduled appointment.

Financial Policy

We accept and bill most major insurance plans and in order to continue this service we ask that you comply by checking with your insurance carrier to make sure we are a participating provider before your appointment. We also ask that you comply with your insurance’s pre-certification, prior-authorization, and co-pay mandates. Please keep our office informed of any changes in your personal, billing, or health information.

**We ask that all co-pays, deductibles, and co-insurances are paid at the time of service.** If surgery is scheduled we ask that deductibles and co-insurances are received prior to the date of surgery. We accept cash, money orders or credit card as forms of payments. We no longer accept personal checks.

For example if you have a co-pay of $25.00 you will be expected to pay that amount at every office visit. Also, if you have a $1000.00 deductible and you have not met your deductible for the year you will be expected to pay the amount in full before surgery. Most insurances pay at 80% until your Out of Pocket is meet. Out of Pockets typically range from $2,000 to $6,000 depending on the insurance company. And so you will be responsible to pay the co-insurance of 20% up until your Out of Pocket is fully meet.

* **FMLA, Disability, Cancer Policy Paperwork:** FMLA, disability (any kind), cancer policies, or any other paperwork that you need filled out or signed require a **$25.00** fee for completion. The fee has to be paid **prior** to completion of paperwork. Paper work must be picked up or it can be **emailed** to you. Our office will not fax paperwork or be responsible for turning it in. If addendum or an update is needed another **$25 fee** will apply.
* **Returned checks:** Payments sent in the mail and are checks that result in to a return check will result into a **$40.00** fee for each returned check. This must be paid along with the amount of the original check by cash or credit card. Any returned checks not paid in a timely manner will be submitted to the District Attorney’s office.
* **Need a copy of your Medical Records?** In accordance to Title 76 torts Section 19, there is a fee for copying for any medical records for you. The fee is **$1.00** for the first page and **$.50** cents per page thereafter.
* **Prescriptions:** Prescriptions not obtained during an office visit require a **$10.00** handling charge per prescription. If a prescription is lost, there will be a **$10.00** fee to rewrite it. These charges are not billed to your insurance and are the patient’s responsibility.
* **Surgery Cancelation Fee:** If you schedule surgery and pre-op has been performed and you choose to cancel surgery there is a **$50.00** fee. If you cause surgery to be cancelled there is a **$50.00** fee. If you choose to move your surgery day and pre-op has already been preformed there is a **$25.00** fee.

**My signature below acknowledges I have completely and thoroughly read understand the above, Office Appointments and Financial Policy and intend to be legally bound hereby.**

 **Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

***Medical Malpractice Arbitration Agreement***

In consideration of the agreement of Jeffrey J. Smith, M.D., Jeffrey J. Smith, M.D., P.C., Bella Vita Med Spa and Smith Cosmetic Surgery Center and his employees, herein called the physician, to render certain medical and surgical services for hereinafter named patient, physician and patient to hereby agree as follows:

1. It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by the laws of the State of Oklahoma, Title 15, Oklahoma Statues, Section 801, et seq., and not by a lawsuit or resort to court process except as the law of the State of Oklahoma provides for judicial review of arbitration proceeding, both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
2. In the event of any claim, demand, controversy, civil action or dispute, including but not limited to personal injury, malpractice, or any tort, whether brought in tort, contract or otherwise, by Patient, his dependents, whether or not minors, heirs at law, or person representatives, against Doctor or any of Doctor’s officers, directors, shareholders, agents, representatives, employees, successors in interest, assigns, staff physicians or associates agreeing in writing to be bound by this arbitration provisions of the agreement (“Affiliates”) ***THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION*** in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to a sole Arbitrator who is a medical doctor and a member of the American Academy of Cosmetic Surgery who shall decide the controversy based on the evidence presented. The arbitrator will be agreed upon by mutual consent of the parties. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be interviewed or joined.
3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all cost, including reasonable attorneys’ fees and the arbitrators’ fees, in prosecuting or defending the claim in arbitration, but not to exceed $2000.00 in amount. Furthermore, if any action is initiated or undertaken to set aside or otherwise attack this arbitration agreement or award, or to compel arbitration, the prevailing party in the court action shall be entitled to all costs of such action, including reasonable attorney’s fees as may be fixed by the court.
4. Any party initiating arbitration under this agreement shall file with his petition a bond or cash surety in the amount equal to One Thousand Dollars ($1,000.00), which shall provide security for attorney’s fees and costs in the event that the moving party should not prevail.
5. Any party initiating a complaint, critical of the other, via a public media, such as internet, TV, radio or print forum, agrees to pay the other party $1,000 and costs to correct the infringement.
6. In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision or provisions shall be stricken and shall be of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity.
7. This agreement shall not limit the ability of the physician, who is or is not covered by malpractice insurance, in the exercise of his professional judgment, to refer the patient to other physicians or to decline further medical treatment to the patient.
8. This agreement shall be construed in accordance with and governed by the law of the State of Oklahoma.

***Medical Malpractice Arbitration Agreement***

This is a binding LEGAL DOCUMENT, which may have an important effect on your legal rights. This agreement provides that all medical controversies shall be decided by an arbitrator agreed upon mutually. Consult your attorney on any questions that you may have.

NOTICE: **By signing this contract you are agreeing to have any medical issue decided by neutral arbitration** and you are giving up the right to a jury or court trial. Please See ARTICLE ONE (1) of this contract.

*Dated this\_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,20\_\_\_\_\_\_\_\_\_\_\_\_*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Jeffrey J. Smith, M.D. Signature*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***\*\*Patient Signature***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Witness*

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Witness*

*State of Oklahoma )*

 *) ss.*

*County of Oklahoma )*

 *I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (****Patient Name****) of lawful age, being first duly sworn, upon oath, state that I am the patient above named; that I have read the foregoing MEDICAL MALPRACTICE ARBITRATION AGREEMENT; that I am familiar with the contents thereof and understand the same; and have been afforded the opportunity for legal counsel prior to the signing thereof.*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 ***\*\*Patient Signature***

 *Before me, the undersigned, a notary public, personally appeared\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,*

*And acknowledged to me that he/she executed the foregoing as his/her own free will.*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Notary Public Signature*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Commission Number

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Commission Expires