



RE: BOHON SENIOR HEALTH CLINIC

Please return all paperwork prior to your appointment, include over the counter medications on your medication list. **(Bring all of your medication bottles to your first appt.)** Bring all insurance cards including medication part “D” card.

Please call ASAP if you need to reschedule your appointment. **In order to provide the highest quality of care to all of our patients, late arrivals may not be able to be seen.**

We thank you in advance for your understanding. We look forward to providing you with the best of care.

**We appreciate you choosing Dr. Jarrell as your health care provider.**

Bohon Senior Medical Clinic  
1223 Swan Drive  
Bartlesville, OK 74006  
Phone 918-214-8081  
Fax 918-333-0734  
[www.abouteldercare.org](http://www.abouteldercare.org)

Excellence in Senior Care Since 1983

# Authorization for Release of Medical Information

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone # \_\_\_\_\_

Address, City, State and Zip \_\_\_\_\_

I hereby authorize

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

**Physician/Facility Name, Address and Phone Number**

To release information from the medical records of the above named patient for the purpose of providing medical treatment and/or consultation.

To: **W.R. Bohon Senior Health Clinic**  
**Jerry B. Jarrell, MD**  
1223 Swan Drive Bartlesville, Ok 74006 Ph.: (918) 214-8081 Fax: (918) 333-0734

Please release copies of physician progress notes, consultations, procedure notes, surgery notes, Laboratory, EKG, Echocardiogram, Spect Scan, CT, MRI, radiology studies, and sleep studies  
For the above named patient for the period of time specified.

Date(s): \_\_\_\_\_

Specify Dates – THIS LINE MUST BE COMPLETED

**This authorization expires 60 days from the date signed below and covers only treatment for dates specified above.**

I, the undersigned, have read the above and authorize the staff of the physician or facility name to disclose such information as herein contained, I understand that this authorization may be withdrawn, by written request from me, at any time to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment, or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. I understand federal and state laws permit a fee to be charged for copying of patient records. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information.

Date \_\_\_\_\_ Signature of Patient/Parent/Conservator/Guardian \_\_\_\_\_ Relationship to patient/Authority to act for patient \_\_\_\_\_

**THIS AUTHORIZATION WILL NOT BE VALID UNLESS ENTIRELY FILLED OUT**

Notice to recipient: The recipient of the enclosed information is not authorized to use this patient's medical records information for any purpose other than for that stated above or to disclose any information to any other person or facility without authorization from the patient to do so.



# Patient Registration Form

Today's Date \_\_\_\_\_

PLEASE PRINT

All information in this packet **MUST** be completed entirely

## PATIENT INFORMATION

Full Legal Name (First) (Middle Initial) (Last)			Nickname
Address		E-Mail Address	
City	State	Zip	Home Phone
Date of Birth	Age	Sex	Cell Phone
Marital Status: Married Widowed Single Divorced			Social Security Number
Employer Name:			Business Phone:
Primary Care Physician:			Other Physicians you see:
Local Pharmacy			Mail Order Pharmacy:

Language, Race, & ethnicity is a Medicare Federal Guideline. You may choose to decline answering information. \_\_\_\_\_ Decline

<b>Primary Language</b>		<b>Race</b>		<b>Ethnicity</b>
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other, Please Specify _____		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American	
		<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race	<input type="checkbox"/> Other Pacific Islander	

## SPOUSE'S INFORMATION

Full Legal Name (First) (Middle Initial) (Last)				
Address (If Different From Above)	City	State	Zip	Home Phone
Employer Name:		Business Phone:		

## INSURANCE INFORMATION

\*\*\*MUST BE COMPLETED\*\*\*

Primary Insurance Company Name	ID/Certificate No.
Member Name	Group No.
Secondary Insurance Company Name	ID/Certificate No.
Member Name	Group No.

## EMERGENCY CONTACT (other than spouse)

Person to Notify in Case of Emergency	Relationship	
Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone

If you have any or all of the following, please provide a copy for our records.

Living Will/Advanced Directive <input type="checkbox"/> YES <input type="checkbox"/> NO	Do Not Resuscitate (DNR) <input type="checkbox"/> YES <input type="checkbox"/> NO	Power of Attorney (POA) <input type="checkbox"/> YES <input type="checkbox"/> NO
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## **Notice of Health Information Practices**

### **Purpose**

This notice describes how medical information about you may be used, disclosed and how you can retrieve access to this information. ***Please review it carefully.***

**Elder Care** believes that the information we gather about you is of a very private nature. We are dedicated to keeping this information confidential. The records we created in providing you with care are by law kept confidential. We are also required to inform you of our policies concerning the use and storage of your personal health information.

**Elder Care** maintains the right to update our Privacy Notice. Your personal information will always be maintained by our current policies designated in our current Privacy Notice. If you have any comments or questions about our Privacy Notice, you may contact our Office Manager: (918) 336-8500 x 106.

### **Privacy Policy**

**The following describes the manner in which we will use and disclose your personal health information:**

1. We may collect and share appropriate information about you to document the necessity of equipment, supplies or services we are providing. Examples include diagnosis, prescription, referral and physician or health care provider information.
2. We may share appropriate information about you to bill and collect payment for the health care we provide to include insurance companies and third parties, which may include family members or other financially responsible parties for which you have given us the information. Examples include insurance coverage and eligibility verification.
3. We may use and disclose information to monitor and operate our business. Examples include health care outcomes and utilization reporting, reports provided to any federal, state, or local authority (as required by law), or to remind you of services needed.
4. We may release appropriate information about you to family or friends that you have designated to help you with the financial responsibilities incurred while receiving services from us.
5. We may use and disclose information about you to respond to a court or legal authoritative body that legally requests information about you. Examples include providing documents for legal subpoenas or discovery proceedings or our staff testifying about the care we have provided.

**The following describes your rights to the information we maintain about you:**

1. You have the right to direct the use of your personal health information.
2. You have the right to request termination or revision of you authorizations or consents that pertain to our use of your personal health information and have those terminations or revisions affect any of our service provisions. We are not required to accept your terms. If we do accept your revisions, we will honor your specifications, except where prohibited by law. All requests must be in written form.
3. You have the right to request a copy of your personal health information as long as any federal, state or local law does not prohibit it. This request must be in writing. There may be a charge for copying, producing and delivering your information.
4. You have the right to request, in writing, a revision to your personal health information, Revision requests will be evaluated on an individual basis and amended if appropriate. Your written request must detail the requested revision and the reasons for the modification. If no explanation is provided, no revision will be made. If we deny your request for amendment, you have the right to file a statement of disagreement.
5. You have the right to request an accounting of non-routine disclosures we have made with your personal health information.
6. You have the right to file a complaint about the use of your personal information with us or the Secretary of the Department of Health and Human Services.



# Bohon Senior Health Care Elder Care Consumer Consent Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, terms may change. If we change our notice, you may obtain a revised copy by asking an Elder Care Privacy Officer for one.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

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**Print Patient Name**

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Patient/Responsible Party **Signature**

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**Date**



# Bohon Senior Health Clinic Information Release

Patient Name \_\_\_\_\_ Date of Birth\_\_\_/\_\_\_/\_\_\_

I **authorize** Elder Care and or the W.R. Bohon Senior Health Clinic to release details, related, to my medical treatment to the individual(s) as listed below:

**PLEASE PRINT**

\_\_\_\_ Spouse \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\* **OR** \*\*\*\*\*

I **DO NOT** authorize Elder Care and or the W.R. Bohon Senior Health Clinic to release details of my treatment to anyone.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## **Bohon Senior Health Clinic Insurance Benefits And Information Release**

I hereby authorize Elder Care and its agents to furnish all information it may have regarding my condition, treatment, and progress to the insurance company or its representatives, my physician, and/or my attorney upon their request or during treatment and progress conferences.

This authorization shall remain valid until revoked by me in writing. Additionally I authorize the payment of medical benefits directly to Elder Care for services rendered and fully accept responsibility for services not fully paid by any insurance company.

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Print Name

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Patient or Responsible Party Signature

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Date

## PHOTO RELEASE

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

Date of Birth: \_\_\_\_\_

I hereby give permission to W.R. Bohon Senior Health Clinic to photograph my likeness for the purpose of identification on my medical records.

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Signature of Patient or Responsible Party

Date





W.R. Bohon Senior Health Clinic

PATIENT MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Current Medical History: Please list the medical conditions currently affecting you or that you are currently receiving treatment.

When did it begin?	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History: Have you been affected by any of the following? If so, when was it first found?

YES	WHEN?	CONDITION	YES	WHEN?	CONDITION
_____	_____	High blood Pressure	_____	_____	Neuropathy
_____	_____	High cholesterol	_____	_____	Seizures
_____	_____	Heart disease, angina	_____	_____	Brain hemorrhage or hematoma
_____	_____	Poor circulation	_____	_____	Meningitis or encephalitis
_____	_____	Diabetes	_____	_____	Severe vision or hearing loss
_____	_____	Thyroid trouble	_____	_____	Hepatitis
_____	_____	Dementia	_____	_____	Cancer
_____	_____	Parkinson's disease	_____	_____	Vitamin deficiency
_____	_____	Serious Head Injury	_____	_____	Asthma-Emphysema
_____	_____	Stroke	_____	_____	Arthritis
_____	_____	Depression			

Other Medical Problems: Please list all medical conditions you have had in the past that are no longer causing you problems.

When did it begin?	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Surgical History:** Please list all operations with the approximate date.

Date	Operation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Psychiatric History:** Please list all mental health or psychiatric conditions or treatments.

Date	Condition or Treatment
_____	_____
_____	_____
_____	_____
_____	_____

**Health Habits**

Have you ever smoked? No \_\_\_ Yes \_\_\_

If yes, how many packs per day and for how many years? \_\_\_\_\_

If you no longer smoke, when did you quit? \_\_\_\_\_

Do you drink alcoholic beverages? No \_\_\_ Yes \_\_\_

If yes, how many drinks per day? (1 drink is 1 beer, 6 oz. of wine, or 2 oz. of hard liquor)

\_\_\_\_\_

Have you ever had a substance abuse problem with alcohol or illicit drugs? No \_\_\_ Yes \_\_\_

If yes, what? \_\_\_\_\_

**Education and Employment**

What is the highest level of formal education completed? \_\_\_\_\_

What was the primary type of work you performed? \_\_\_\_\_

What other jobs have you held? \_\_\_\_\_

\_\_\_\_\_

Have you ever worked with chemicals, solvents, or heavy metals (for example, lead)? No \_\_\_ Yes \_\_\_

If yes, which ones? \_\_\_\_\_

Do you have any history of exposure to radiation or radiation therapy? No \_\_\_ Yes \_\_\_

**Family History:** Please indicate which family members have had any of the following medical conditions  
(give the relationship to the person, not the relative's name)

Condition	Family Member(s)
Alzheimer's Disease or Dementia	_____
Parkinson's Disease	_____
Depression	_____
Stroke	_____
Heart Disease	_____
Cancer	_____
Diabetes	_____

**Prescription Medication History:** Please list all prescription medicines that you are currently taking.

Name of medication	Strength and times per day
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Over-the Counter Medication History:** Please list all over-the-counter medicines you are currently taking at least once a week.

Name of medication	Strength and times per day
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Allergies:** Please list all medicines that you are allergic to.

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



W.R. Bohon Senior Health Clinic

Name \_\_\_\_\_

Date \_\_\_\_\_

General Health Assessment	Yes	No	Notes
Fever			
Chills			
Fatigue			
Change in appetite			
Recent weight changes			
Sweats			

Cardiology	Yes	No	Notes
Leg edema			
Syncope			
Chest pain			
Palpitations			
Blood pressure readings			

Respiratory	Yes	No	Notes
Wheezing			
Cough			
Snoring			
Coughing or choking While eating or drinking			

Gastroenterology	Yes	No	Notes
Bowel habit change			
Nausea			
Heartburn			
Vomiting			
Abdominal pain			
Diarrhea			
Blood in stool			
Constipation			

ENT	Yes	No	Notes
Hearing loss			
Dry mouth			
Sense of smell			
Change in voice			

Thyroid	Yes	No	Notes
Heat intolerance			
Cold intolerance			
Hoarseness			
Lethargy			
Neurology	Yes	No	Notes

Tremor			
Restless			
Hemiparesis			
Difficulty swallowing			
Headache			
Insomnia			
Dizziness			

<b>Musculoskeletal</b>	Yes	No	Notes
Joint pain			
Muscle pain			
Back pain			

<b>Urology</b>	Yes	No	Notes
Dysuria			
Weak stream			
Difficulty urinating			
Nocturia			
Incontinence			

<b>Hematology</b>	Yes	No	Notes
Swollen glands			
Easy bruising			

<b>Female Reproductive</b>	Yes	No	Notes
Breast pain			
Hot flashes			
Breast lump			
Breast tissue changes			
Post-Menopausal bleeding			

<b>Dermatology</b>	Yes	No	Notes
Rash			
Mole changes			

<b>Ophthalmology</b>	Yes	No	Notes
Blurry/double vision			
Loss of vision			

<b>Psychology</b>	Yes	No	Notes
Sleep disturbance			
Anxiety			
Depression			