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*

Primary Language	Race	Ethnicity
☐ English ☐ Spanish	☐ American Indian or Alaska Native ☐ Asian	Hispanic or Latino
☐ Other, Please Specify	☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American	☐ Yes ☐ No
_____	☐ White ☐ Hispanic ☐ Other Race ☐ 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.

Advance Directive ☐ YES ☐ NO	DNR: ☐ YES ☐ NO	POA: ☐ YES ☐ NO

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 ENTIRLEY 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.

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.

_____

Print Patient Name

_____

Patient/Responsible Party **Signature**

_____

Date

1223 Swan Drive Bartlesville, OK 74006 918-214-8081
www.abouteldercare.org Fax: 918-333-0734
Revised 12/16/16

elder care

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

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 have 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.

Review of Symptoms: Have you experienced any of the following problems in the past three years? Please describe any problems briefly, with approximate dates. If you need more room, please attach an additional sheet. Leave the blank empty if the problem has not occurred.

Problem	Description, Date(s)
Change in personality	
Trouble talking, finding words	
Weakness on one side	
Poor judgment	
Episodes of severe confusion	
Loss of alertness, inability to wake up	
Believing something that is obviously not true	
Cries, gets angry without reason	
Vision or hearing loss	
Problem with teeth, gums	
Injury from a fall	
Trouble with balancing, walking	
Snoring loudly, gasping for breath while sleeping	
Shortness of breath	
Chronic coughing	
Change in bowel habits	
Bleeding from the rectum	
Increased or decreased interest in sex	
Trouble with urination, incontinence	
Pain in joints or bones	
Limited movement of arms, legs	
Bleeding or enlarged spots on skin	
Unusual skin dryness or sweating	
Changes in appetite	
Unusual thirst	
Extreme fatigue	
Change in sleep habits	
Weight loss or gain	
Inability to prepare or eat food	

Bohon Senior Health Clinic
Current Medication List

Complete the information below regarding all medications you are currently taking.

Be certain to list both prescription and non-prescription medication,
including any herbals or supplements.

Name _____ Date _____

Example: Reglan	10mg	3x daily	Reason
Medication	Dosage	How Often	Stomach Problems

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

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www.aboutheldercare.org Fax: 918-333-0734
Revised 12/16/16

W.R. Bohon Senior Health Clinic

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.

_____

Signature of Patient or Responsible Party Date

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