RE: W. R. BOHON HEALTH CLINIC

Thank you for choosing Dr. Jarrell and Tracy Stuckey, CNP, as your health care providers. All paperwork should be returned with copies of insurance cards, including Medicare part "D", if this applies to you. Once we have received your completed packet and insurance information, please allow us sufficient time to obtain your medical records before we are able to call to schedule your initial appointment.

- Please include all physicians or facilities we can obtain records from on the "Authorization for Release of Medical Information", so we can piece together an accurate medical history on you.
- Please include over the counter medications on your medication list and be sure to bring all medication bottles to your first appointment.

Call us as soon as possible if you need to reschedule your initial appointment. We thank you in advance and we look forward to providing you with the best of care.

W. R. Bohon Health Clinic

1223 Swan Drive

Bartlesville, OK 74006

Phone 918-214-8081

Fax 918-333-0734

www.AboutElderCare.org

Excellence in Senior Care Since 1983

W. R. BOHON HEALTH CLINIC

Patient Registration Form
Today's Date _____

PATIENT INFORMATION. PLEASE PRINT All information in this packet MUST be completed entirely

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 □ Other, Please Specify _____	□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ Other Race □ White	Hispanic or Latino □ Yes □ No

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	**Do Not Resuscitate (DNR)**	**Power of Attorney (POA)**
□ **YES** □ **NO**	□ **YES** □ **NO**	□ **YES** □ **NO**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ SSN _____

Birth Date _____ / _____ / _____ Telephone # _____

Address, City, State, Zip _____

I hereby authorize

Primary Care Physician _____ Nephrology _____

Orthopedic Physician _____ Oncology _____

Home Health Agency _____ Neurology _____

Other physicians, facilities, or home health providers:

_____

_____

_____

Physician / City

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 Health Clinic
Jerry B. Jarrell, MD
1223 swan Drive Bartlesville, Oklahoma 74006 Ph.: (918) 336-8500 Fax: (918) 333-0734

Please release copies Of Medical History and Medical Summaries for the above-named patient for the period specified. P**hysician 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 MUST BE completed

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

l. the undersigned, have read the above and authorize the staff of the physician or facility named 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 net authorized use this patient's Medical Records for any purpose other than for that stated above or to disclose any information to any other person or facility without specific written authorization from the patient do so.

1223 Swan Drive Bartlesville, OK 74006 | (918) 214-8081
AboutElderCare.org | Fax: 918-333-0734

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 your 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 Health Clinic
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 healthcare 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. This form will stay in effect until revoked by you or the responsible party. 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

Bohon Health Clinic
Information Release

Patient Name _____ Date of Birth__/__/____

I **authorize** Elder Care and or the W.R. Bohon 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 Health Clinic to release details of my treatment to anyone.

_____

Patient Signature Date

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AboutElderCare.org | Fax: 918·333·0734
Revised 12/16/16

Bohon 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 and for services rendered and fully accept responsibility for services not fully paid by any insurance company.

_____

Print Name

_____ _____

Patient or Responsible Party Signature Date

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Revised 12/16/16

Bohon Health Clinic
Photography Release

Patient Name_____

Date of Birth___/___/_____

I hereby authorize Elder Care to photograph my likeness for the purpose of identification on my medical record.

_____

Print Name

_____

Signature of Patient or Responsible Party Date

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AboutElderCare.org | Fax: 918·333·0734
Revised 12/16/16

W.R. Bohon 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/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	Operation
_____	_____
_____	_____
_____	_____
_____	_____

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 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.

_____

_____

_____

Date_____

Name_____

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			
Leg edema			
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			

Musculoskeletal	Yes	No	Notes
Joint pain			
Muscle pain			
Back pain			

Urology	Yes	No	Notes
Dysuria			
Weak stream			
Difficulty urinating			
Nocturia			
Incontinence			

Hematology	Yes	No	Notes
Swollen glands			
Easy bruising			

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

Dermatology	Yes	No	Notes
Rash			
Mole changes			

Ophthalmology	Yes	No	Notes
Blurry/double vision			
Loss of vision			

Psychology	Yes	No	Notes
Sleep disturbance			
Anxiety			
Depression			