

Oklahoma City Gynecology and Obstetrics, LLC

Permission for Disclosure of Protected Health Information.

I hereby acknowledge that I received a copy of this medical practice's *Notice of Privacy Practices*. I further acknowledge that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment.

I, _____, give my permission for Oklahoma City Gynecology and Obstetrics to give information to the people listed below about my medical care. This information may include lab results, medications being taken, appointment times, changes in appointments, x-ray results, doctor or nurse reports about me, and any other information that this office has about me. (Please do NOT include other physicians or your employer in this list.) It is my responsibility to keep the office updated on any changes in my personal information.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Signature of Patient

Date

Witness Signature

Date

OPPORTUNITY TO OBJECT

I, _____, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

Signature of Patient / Personal Representative

Date

Witness Signature

Date

**OKC Gynecology and Obstetrics
Patient Information / Disclosure Agreement**

Doctor: _____

Patient Last Name: _____ First Name: _____ Middle Init.: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work#: _____ Ext: _____ Mobile: _____

Date of Birth: _____ SS#: _____ - _____ - _____ Marital Status: _____

E-mail: _____ Race: _____

Pharmacy: _____ Pharmacy Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

My Insurance requires lab/blood work to be sent to: _____. (If no lab is identified, all Lab/blood work will be sent to the hospital's contracted lab.)

REASON FOR TODAY'S VISIT

Routine Preventative Exam: (I have no medical complaint or problem of which I am aware.) **Medicare will not cover.**

Routine Preventative Exam AND the Following Problem that I wish to be evaluated/ treated:

 I have a Problem/ Complaint that I wish to have evaluated/ treated. My Chief Complaint Is:

Physicians of NW Oklahoma City, LLC (Susan L. Chambers, Deborah L. Huff, Laura L. Mackie, Jennifer K. Nelson, Valerie A. Engelbrecht, Virginia L. Vaughan, Dana G. Stone, Margaret A. Hall, Chris Davis, Jennifer McNeil, Lisa Wasemiller-Smith, and William Miller) are owners of Lakeside Women's Hospital. We refer patients there because it is convenient and efficient for patients, and the quality of care is excellent. We believe that patients have a choice in the selection of health care facilities. If you wish to use another facility, please let us know.

Lakeside Women's Hospital has arranged for one or more physicians to be on-site at the Hospital and available to respond for medical emergencies during most hours of operation. However, we cannot guarantee that a physician will be present at the Hospital at all times. The Hospital has taken certain measures to ensure that qualified and properly trained medical personnel are available to respond to any medical emergency that may arise when a physician is not present at the Hospital.

I hereby authorize the physicians of the Oklahoma City Gynecology and Obstetrics, LLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Oklahoma City Gynecology and Obstetrics, LLC all payments for medical services rendered to myself or my dependents. I understand that the information authorized for release may include information, which may be considered a communicable, or venereal disease.

I agree to pay for any and all medical services I receive from the doctor that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf (if contracted). I will pay these charges upon written/ verbal notice of their refusal. Failure of your insurance company to pay within 45 days of claim filing date will be considered a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical records. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay charges when due, for these or any other services provided me, I agree to pay all cost of collection, including reasonable attorney Fees.

I am aware that if laboratory (including pap smear, blood and urine testing, and biopsies) is obtained, there will be a separate charge from the pathology laboratory for this examination.

Patient Signature: _____ Date: _____

Parent Signature if Minor: _____ Date: _____

A photocopy of the authorization and assignment shall be considered as valid as the original.

PAST MEDICAL HISTORY <input type="checkbox"/> None		
<input type="checkbox"/> AIDS/ HIV	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> Anesthesia complications	<input type="checkbox"/> Female/Sexual Problems	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Headaches or Migraines	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> Arthritis/Lupus	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Birth Defects or Inherited Disease	<input type="checkbox"/> Herpes (HSV)	<input type="checkbox"/> Sexual Abuse/Domestic Violence
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach/Bowel/Gall Bladder Problems
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Breast Problem	<input type="checkbox"/> Infertility	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney or Bladder Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chlamydia/Gonorrhea	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Varicosities
<input type="checkbox"/> Depression	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Other:

SOCIAL HISTORY/LIFESTYLE	
Occupation:	Is sexual intercourse painful? (Y/N):
Religion:	History of sexually transmitted infection:
General Stress Level (Low/Medium/High):	Current Birth Control Method:
Diet (Regular/Vegetarian/etc.):	Smoking Status (Never/Former/etc.):
Exercise Level (Occasional/Moderate/Heavy):	Smoking (How much per day/week?):
Marital Status: (S / M / D / W)	Alcohol Intake- (#Drinks per week?): None, 0-5, 6-14, >14
Sexual Orientation: (Heterosexual/ Homosexual/ Bisexual)	Caffeine Intake (None/Occasional/Moderate/Heavy):
Sexually Active (Y/N):	Illicit Drugs:
How many years have you been sexually active?	Hours of sleep each night? (approx.):

HOSPITALIZATIONS/SURGICAL PROCEDURES <input type="checkbox"/> None		
Month/Year	Illness/Operation	Complication (Y/N)

VACCINE HISTORY: LIST RECENT VACCINATIONS <input type="checkbox"/> None	
Name of vaccine:	Date:
Tdap/Tetanus (Last 10 years?) Y/N	
Pneumonia: Y/N	
Gardasil (HPV): Y/N	
Shingles: Y/N	
Flu: Y/N	

FAMILY HISTORY: (IF YOU CHECK YES PLEASE LIST RELATION) <input type="checkbox"/> None		
<input type="checkbox"/> AIDS (HIV)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Anesthesia complications	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis/Lupus
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Uterine Cancer
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Other: