Stillwater **Cancer Center**

A DIVISION OF STILLWATER MEDICAL PARTNERING WITH OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

1201 W. 6th Ave. Stillwater, OK 74074
PHONE: 405-742-4930 FAX: 405-742-4917

PATIENT DEMOGRAPHICS

Personal Information:

Name: _____ Social Security#_____
Date of Birth: _____ Age: _____ Marital Status: _____ Race: _____
Home Address: _____ City/State/Zip: _____
Home/Cell Phone Number: _____ Alternate Phone Number: _____
Email Address: _____
Spouse's Name: _____ Spouse's Date of Birth: _____
Spouse's Phone Number: _____ Spouse's Work Phone Number: _____
Spouse's Employer (Including City, State, Zip): _____
_____
Preferred Pharmacy: _____

Employment Information:

Disabled ( ) Full-Time ( ) Part-Time ( ) Retired ( ) Self-Employed ( ) Student ( )
Employer (Including City, State, Zip): _____
Telephone Number: _____ _____ Extension: _____
Job Title/Description: _____

Person(s), <u>not</u> living with you, to contact if unable to reach you or your spouse:

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____

Physician Information:

Referring Physician: _____ City/State _____ Phone Number: _____
Primary Care Physician: _____ City/State: _____ Phone Number: _____

Financial Information (Do not complete <u>IF</u> we scanned your cards):

Primary Insurance: _____ Group #: _____ Membership ID #: _____
Who is the Insured/Subscriber? _____ Covers: Self ( ) Family ( )
Subscriber's SSN#: _____ Subscriber's DOB: _____

Secondary Insurance: _____ Group #: _____ Membership ID#: _____
Who is the Insured/ Subscriber? _____ Covers: Self ( ) Family ( )
Subscriber's SSN#: _____ Subscriber's DOB: _____

I hereby authorize my physician to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments for medical services rendered to me.

Patient's Signature: _____ **Date:** _____

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PATIENT HISTORY FORM

Your physician will have more time to talk to you and be able to do a more thorough job if he or she can quickly learn about your health background. All of the information you provide will be confidential and will remain filed on your medical chart. Please fill in the following information prior to your visit. (PLEASE PRINT)

TODAY'S DATE_____/ ___/ _____ DATE OF LAST PHYSICAL EXAM ___ /___ / __

LAST NAME_____ FIRST NAME _____ MIDDLE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH_____/_____/_____

DO YOU HAVE THE FOLLOWING? (CIRCLE)

AN ADVANCED DIRECTIVE LIVING WILL POWER OF ATTORNEY

If you do not have any of the above, would you like information on these options? YES NO

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

PHARMACY_____ PHARMACY PHONE NUMBER _____

HISTORY OF PRESENT ILLNESS

Please answer the following questions (please circle).

- Are you pregnant? YES NO Are you trying to get pregnant? YES NO

  If you are of childbearing age, are you on any form of contraceptives (birth control)? YES NO
  If yes please describe _____
- Have you had a recent weight gain or loss? YES NO If yes, how much and when?_____

ALLERGIES

- Are you allergic to any medications — drugs? (Please Circle) YES NO

DRUGS:	REACTION:
1.	
2.	
3.	
4.	
5.	

Are you allergic to: IODINE ADHESIVE TAPE PLASTIC BANDAGES
MERTHIOLATE LATEX OTHER:_____

_____

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MEDICINES

Do you take prescription medications presently? (Please Circle) YES NO

If so, please list the medication (including dosage), when you take them, and why you take them below:

MEDICATIONS	DOSAGE/ MG	HOW MANY TIMES PER DAY?	WHY DO YOU TAKE THIS MEDICATION?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you take non-prescription medications? For example: Aspirin, Tylenol, laxatives, diet pills, vitamins, antacids, herbal remedies, supplements, or cold remedies? (Please Circle) YES NO

If so, please list them, when you take them, and why you take them below:

MEDICATIONS	DOSAGE/MG	HOW MANY TIMES PER DAY?	WHY DO YOU TAKE THIS MEDICATION?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8			
9.			
10.			

HABITS

HAVE YOU EVER SMOKED? YES NO **DO YOU CURRENTLY SMOKE?** YES NO **WHEN DID YOU QUIT?** _____

CIRCLE ONE: CIGARETTES PIPE CIGAR NONE

IF YES: DAILY AMOUNT _____ **HOW MANY YEARS HAVE YOU SMOKED?** _____

DO YOU DRINK ALCOHOL? YES NO **HOW MUCH DO YOU DRINK EACH WEEK?** _____

HOW OFTEN DO YOU DRINK? _____

CIRCLE ONE: BEER WINE LIQUORS OTHER NONE

HAVE YOU EVER USED ILLEGAL OR ILLICIT DRUGS? YES NO **IF SO, WHICH ONES?** _____

HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT? _____ **HOW MANY MEALS PER DAY?** _____

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FAMILY HEALTH HISTORY

Please list your family members and their health status: (if there is not enough room, please use the back of this page)

FAMILY MEMBER	YEAR BORN	IF LIVING - PRESENT HEALTH: GOOD	IF LIVING - PRESENT HEALTH: FAIR	IF LIVING - PRESENT HEALTH: POOR	IF NOT LIVING AGE OF DEATH	CAUSE OF DEATH
MOTHER:						
FATHER:						
BROTHERS/SISTERS (PLEASE LIST):						
CHILDREN (PLEASE LIST):						

- Does anyone in your family have heart disease? (Please circle) YES NO
- Does anyone in your family have high blood pressure? YES NO
- Does anyone in your family have a blood disorder? YES NO
- Does anyone in your family have diabetes? YES NO
- Does anyone in your family have a history of cancer? YES NO

PAST MEDICAL HISTORY

Please list all of your prior hospitalizations, operations, and chronic problems:

ILLNESS / OPERATION	WHERE	YEAR

● CONSENT FOR CARE

I, or my representative, hereby consent to medical treatment, diagnostic and/or therapeutic services as ordered by my physician and his/her designee(s). I further understand that my physician may order an HIV antibody (AIDS) test as part of diagnosis and treatment.

If I am an obstetrical patient admitted to the hospital for the delivery of my baby, I also consent to hospital care of my infant(s) encompassing diagnostic procedures, including but not limited to laboratory testing, and medical treatment.

I understand that photographs or video may be used for identification purposes and to aid in or document my treatment. Photographs in the medical record will be handled according to customary medical record privacy practices.

I understand that with the exception of physicians employed by the hospital, the physicians on staff at Stillwater Medical Center, such as emergency room physicians, radiologists, anesthesiologists, and pathologists are not employees or agents of the hospital but are independent contractors/agents who have been granted privileges to use the hospital facilities.

● AUTHORIZATION TO RELEASE/OBTAIN INFORMATION FOR TREATMENT, PAYMENT, OR OPERATIONS; TO MY PATIENT PORTAL AND THE HEALTH INFORMATION

I am aware that medical information will be released or obtained in order to get assistance in continued medical treatment, paying of bills or other routine operations of the hospital; to my patient portal and health information exchange. The information authorized for release may include records which may indicate the presence of a communicable disease or non-communicable disease. I have received a copy of the Notice of Information Practices (Privacy Notice) that describes how this information is used and may request another copy at any time**.**

● AUTHORIZATION TO CONTACT

I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

● VALUABLES AND PERSONAL BELONGINGS

Stillwater Medical Center is not responsible for personal valuables left at the bedside or retained on the person. This includes, but is not limited to electronic equipment, glasses, dentures, hearing or other prosthetic devices. (A HOSPITAL SAFE IS AVAILABLE FOR DEPOSIT OF VALUABLES UPON REQUEST).

● INSURANCE PRE-CERTIFICATION

I hereby expressly understand I am responsible for notification to my insurance company to obtain authorization before service is rendered. I understand if this note is not done, insurance benefits may be reduced.

● PATIENT RIGHTS

I have read and received a copy of the Patient Rights. Patient Rights are posted in the Patients and Visitors Handbook available in each inpatient room and all outpatient−waiting areas.

● ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, THIRD PARTU LIABILITY/AND BILLING

I, or legal guardian, assign and transfer all benefits, monies, and sums payable for hospitalization, sickness or accident under any hospitalization, (including major medical and supplemental benefits), sickness or accident policy providing for hospital payment.

I, or legal guardian, will be responsible for any amount due in consideration of services rendered at Stillwater Medical Center. Amounts estimated or known to be payable by the patient become due and payable at the time of discharge (including, but not limited to, non−covered services, health insurance deductible, and coinsurance amounts). This includes hospital−based physicians and contractual physician services that may bill separately for their professional services.

If this service is for treatment of an injury, illness or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, the patient agrees to give the hospital a lien, up to the amount of the outstanding charges, on any recovery the patient makes from the third party of any uninsured or underinsured motorist coverage of the patient, the patient's parents, patient's spouse, or patient's guardian. The patient further agrees that if there is no third party recovery or recovery from uninsured or underinsured motorist coverage, the patient, or legal guardian is still responsible for payment of the outstanding charges.

● MEDICARE ASSIGNMENT OF BENEFITS

I, or representative, certify the information given in applying for payment under Title XVIII of the Social Security Act is correct. Release of information related to this Medicare claim to the Social Security Administration or its intermediaries and carriers is authorized. Request of payment of authorized benefits to Stillwater Medical Center is authorized.

● MSG—MEDICARE MESSAGE (Medicare Inpatient Only)

The federal government requires we provide to you written information regarding your rights as a Medicare hospital patient. You will receive information that includes the procedure for initiation, review, and resolution of complaints.

● MSP QUESTIONNAIRE (Medicare Secondary Payor)

The government requires we request additional information from you to determine if there is any other resource for payment that could be primary to Medicare.

The undersigned certifies that she/he has read the above information or it has been explained so that she/he understands. Signatures also indicate she/he has been offered information on privacy and patient rights, including the procedure for initiation of complaints.

PRINT PATIENT NAME:	SIGNATURE PATIENT/GUARANTOR/GUARDIAN:
BIRTH DATE:	DATE:

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security # _____ Telephone: _____

FOR OFFICE/NURSE USE ONLY:

Information to Be Released: Covering the Periods of Health Care

From (date) _____ to _____

From (date) _____ to _____

Please check type of information to be released:

__Pertinent documentation __Operative Report __Lab results __Complete health record

__History and Physical __Consulting reports __Progress notes __EKG

__Discharge Summary __X-ray reports __X-ray films/images __EEG

__Photographs, videotapes __Complete billing file __Itemized bill __**All Records**

__Other, (specify) _____

Purpose of Request

____ Treatment or Consultation _____ At the request of the patient ___Billing or Claims payment

____ All____ Other (specify)_____

I, the undersigned authorize and request The Cancer Center, A Division of Stillwater Medical Center to: ___Release information to:___Obtain information from:

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing; HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release:

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on the authorization, at any time **I** can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at {1201 W. 6th St., Stillwater, OK 74074}. Unless revoked, this authorization will expire on the date above or one year from the date of signature unless otherwise specified.

Re-Disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign the authorization or payment for services will be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I **authorize Stillwater Cancer Center, A Division of Stillwater Medical Center, to use and disclose the protected health information specified above.**

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Representative Date

_____ _____

Representative's Relation to Patient Expiration Date

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CONSENT TO DISCUSS PATIENT'S MEDICAL CONDITION WITH FAMILY OR FRIENDS

I, _____
GIVE THE PHYSICIANS AND STAFF OF THE CANCER CENTER, A DIVISION OF STILLWATER MEDICAL CENTER, PERMISSION TO DISCUSS MY MEDICAL CONDTITION WITH THE **FAMILY MEMBERS & FRIENDS LISTED BELOW:**

Name: _____ Relationship: _____
Phone Number: _____

Name: _____ Relationship: _____
Phone Number: _____

Name: _____ Relationship: _____
Phone Number: _____

Name: _____ Relationship: _____
Phone Number: _____

Name: _____ Relationship: _____
Phone Number: _____

Name: _____ Relationship: _____
Phone Number: _____

Name: _____ Relationship: _____
Phone Number: _____

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED

_____ _____

PATIENT SIGNATURE DATE

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Stillwater Cancer Center, originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any 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.
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of health care 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 Stillwater Cancer Center 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, but not limited to, records involving diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I hereby give my permission for any employee of Stillwater Cancer Center to leave messages regarding my care or appointments with family members or on my answering device.

PATIENT SIGNATURE: _____ DATE: _____