STILLWATER
Diabetes & Endocrinology

610 S. Walnut Ave
Stillwater, OK 74074

Phone: 405.742.4936
Email: stwdiab@stillwater-medical.org

Legal Name: ________________________________________________

Last First Middle

Preferred Name ________________________________________________

SSN ________-__________-________ Date of Birth ____________________ Gender ______________

Billing Address ________________________________________________

City ______________________________ State ______________ Zip ______________

(if different than billing)

Mailing Address ________________________________________________

City ______________________________ State ______________ Zip ______________

Phone Number ______________________________ Alternate Phone ______________________________

**Race:** ☐ Asian ☐ White ☐ Native American ☐ Pacific Islander ☐ Multi-racial ☐ Hispanic
☐ African American ☐ American Indian ☐ Unknown

**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic/Latino

**Marital Status** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Life Partner ☐ Legally Separated

Language ______________________________ Religion ______________________________

Email address ________________________________________________

Emergency Contact ______________________________ Phone ______________________________

Employer ________________________________________________

Insurance Company ________________________________________________

Guarantor (if patient is a minor) ______________________________ Relationship ______________

Address ______________________________ City ______________ State ________ Zip ______________

Date of Birth ______________ Home Phone ______________________ Cell Phone ______________________

I request payment of authorized Medicare and/or commercial insurance benefits to me or on my behalf for any services furnished me by or in SMC. I authorize any holder of medical or other information about me to release to Medicare and/or commercial insurance and its agents any information needed to determine these benefits or benefits for related services. A photocopy of this release shall be considered effective and as valid as the original.

Payment in full may be required at the time of service. For your convenience, we accept personal checks, credit card, and cash. Any medical insurance you may have is intended to protect you against financial loss, but payment in full for your care is your responsibility regardless of insurance coverage.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party. I will make sure that my claims are paid promptly. A photocopy of this release shall be considered effective and as valid as the original.

Signature of Patient ________________________________________________ Date ______________

*Print Name*_______________________________________ *D.O.B*____________________

The Notice of Privacy Practices, which explains how your health information is protected, is available at the front desk. Please let us know if you have any questions regarding the Notice of Privacy Practices by contacting our front office, or discussing with your physician.

1. I do______ do not______ authorize messages containing medical information to be left on my voicemail at phone number______________________________
2. You may _____may not_____ call me and/or leave voicemail at my workplace number____________________
3. You may discuss my medical information with the following people:
   Name___________________ Phone___________________
   Name___________________ Phone___________________
   Name___________________ Phone___________________

Your signature indicates that you are aware of the privacy practices at the Diabetes & Endocrinology Clinic.

____________________________________/______________ ____________ ____________
Patient (or representative) signature Relationship to patient Date Time

# STILLWATER MEDICAL CENTER
## Assignment of Benefits

### 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 care may be provided to me by students performing under the supervision of hospital or medical staff.

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, 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 EXCHANGE

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. I have been provided 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.

### 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 is not done, insurance benefits may be reduced.

### 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).

### PATIENT RIGHTS

I have been provided 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 PARTY 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.

### MOON—MEDICARE OUTPATIENT OBSERVATION NOTICE (Medicare Observation Only)

The federal government requires we provide to you written information regarding your outpatient observation status and the implications of receiving such services.

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

| SIGNATURE OF PATIENT OR REPRESENTATIVE: | RELATIONSHIP TO PATIENT: | WITNESS: |
|---|---|---|
| RESPONSIBLE PARTY/INSURED (if different): | RELATIONSHIP TO PATIENT: | DATE: |

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 405-372-1480
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 405-372-1480

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Name: ______________________ DOB: ____________ Date: ____________

Reason for Visit: ______________________________________________

**Other physicians you see or have seen:**

| Name | Address | Phone and fax numbers |
|---|---|---|
| Primary Care | | |
| Other Endocrinologist | | |
| Cardiologist | | |
| Nephrologist | | |
| Podiatrist | | |
| Other (GYN, GI, URO) | | |
| | | |
| | | |

Pharmacies you use:

| Name | Address | Phone and fax numbers |
|---|---|---|
| | | |
| | | |

**Medical problems you have:**

Arthritis ☐ Yes ☐ No

Autoimmune Disease ☐ Yes ☐ No

Bone Fractures after age 50 ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Please specify: ______________

Chronic Kidney Disease ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Kidney Stones ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Sleep Apnea ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid Problems ☐ Yes ☐ No

Complications of diabetes: ☐ Yes ☐ No

(Examples: amputations, neuropathy, diabetic retinopathy Gastroparesis)

**Surgeries:**

Bariatric Surgery ☐ Yes ☐ No

Colonoscopy ☐ Yes ☐ No

Eye Surgery ☐ Yes ☐ No

Gallbladder ☐ Yes ☐ No

Heart Surgery ☐ Yes ☐ No

Hysterectomy ☐ Yes ☐ No

Ovaries removed? ☐ Yes ☐ No

Thyroid Surgery ☐ Yes ☐ No

Do you smoke/use tobacco products? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

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**Please Identify *immediate biological relatives* with any of the following health problems:** Adopted ☐

Arthritis ☐ Yes ☐ No If yes, Who? ______________________

Autoimmune Disease ☐ Yes ☐ No If yes, Who? ______________________

Bone Fractures after age 50 ☐ Yes ☐ No If yes, Who? ______________________

Cancer Please specify ______________ ☐ Yes ☐ No If yes, Who? ______________________

Chronic Kidney Disease ☐ Yes ☐ No If yes, Who? ______________________

Diabetes ☐ Yes ☐ No If yes, Who? ______________________

Heart Disease ☐ Yes ☐ No If yes, Who? ______________________

High Blood Pressure ☐ Yes ☐ No If yes, Who? ______________________

High Cholesterol ☐ Yes ☐ No If yes, Who? ______________________

Kidney Stones ☐ Yes ☐ No If yes, Who? ______________________

Osteoporosis ☐ Yes ☐ No If yes, Who? ______________________

Sleep Apnea ☐ Yes ☐ No If yes, Who? ______________________

Stroke ☐ Yes ☐ No If yes, Who? ______________________

Thyroid Problems ☐ Yes ☐ No If yes, Who? ______________________

**Medication Allergies:** ______________________________________________

**Medications you have previously tried and failed for the condition you are being seen for today:**

| Name | Dose | Frequency | Reason Discontinued |
|---|---|---|---|
| | | | |
| | | | |

**Medications/vitamins you take: Need additional space, please attach separate page**

| Name of Medication/Vitamin | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Signature: ______________________________ Date: ____________

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Patient Name ______________________ Date of Birth ____________

# Review of Systems-New Patient

Please circle any of these problems you have had in the **last 2-3 months**.

**General:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fever | ☐ Yes | ☐ No | Chills | ☐ Yes | ☐ No | Sweats | ☐ Yes | ☐ No |
| Weakness | ☐ Yes | ☐ No | Fatigue | ☐ Yes | ☐ No | Weight Gain | ☐ Yes | ☐ No |
| Weight Loss | ☐ Yes | ☐ No | | | | | | |

**Eyes:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Blurry Vision | ☐ Yes | ☐ No | Double Vision | ☐ Yes | ☐ No | Dry Eyes | ☐ Yes | ☐ No |
| Eye Pains | ☐ Yes | ☐ No | Floaters | ☐ Yes | ☐ No | | | |

**Ears/Nose/Mouth:**

Decreased Hearing ☐ Yes ☐ No Hoarse Voice ☐ Yes ☐ No Sore Throat ☐ Yes ☐ No Dry Mouth ☐ Yes ☐ No

**Lungs:**

| | | | | | |
|---|---|---|---|---|---|
| Unusual Shortness of Breath | ☐ Yes | ☐ No | Cough | ☐ Yes | ☐ No |
| Bloody Sputum | ☐ Yes | ☐ No | Wheezing | ☐ Yes | ☐ No |
| Pain with Breathing | ☐ Yes | ☐ No | Snoring | ☐ Yes | ☐ No |

**Heart:**

| | | | | | |
|---|---|---|---|---|---|
| Chest Pain | ☐ Yes | ☐ No | Palpitations | ☐ Yes | ☐ No |
| Leg Cramps when **Walking** | ☐ Yes | ☐ No | Leg Swelling | ☐ Yes | ☐ No |

**Gastrointestinal:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Nausea | ☐ Yes | ☐ No | Vomiting | ☐ Yes | ☐ No | Constipation | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No | Bloating | ☐ Yes | ☐ No | Bloody Stools | ☐ Yes | ☐ No |
| Change in Stool Consistency | ☐ Yes | ☐ No | | | | Food Sticks with Swallowing | ☐ Yes | ☐ No |

**Genitourinary:**

| | | | | | |
|---|---|---|---|---|---|
| Pain with Urination | ☐ Yes | ☐ No | Bloody Urine | ☐ Yes | ☐ No |
| Urinary Incontinence | ☐ Yes | ☐ No | Incomplete Emptying of Bladder | ☐ Yes | ☐ No |
| Impotence | ☐ Yes | ☐ No | | | |

**Hematologic:** Anemia ☐ Yes ☐ No Swollen Glands in Neck ☐ Yes ☐ No

**Endocrine:**

| | | | | | |
|---|---|---|---|---|---|
| Always Cold | ☐ Yes | ☐ No | Always Hot | ☐ Yes | ☐ No |
| Change in Menstrual Cycle | ☐ Yes | ☐ No | Change in Hair Texture | ☐ Yes | ☐ No |
| Flushing | ☐ Yes | ☐ No | Loss of Height | ☐ Yes | ☐ No |
| Passing Out | ☐ Yes | ☐ No | Unexplained Broken Bones | ☐ Yes | ☐ No |
| Unexplained Change in Skin Pigmentation | ☐ Yes | ☐ No | | | |

**Musculoskeletal:**

| | | | | | |
|---|---|---|---|---|---|
| Joint Pain | ☐ Yes | ☐ No | Recent Broken Bone | ☐ Yes | ☐ No |
| Muscle Cramps | ☐ Yes | ☐ No | Muscle Weakness | ☐ Yes | ☐ No |

**Skin:** Rash, Itching, Dry Skin

**Neurologic:** Numbness, Tingling, Unusual Headaches, Tremor

**Psychiatric:** Anxiety, Depression, Sleeping Problems