Welcome to

ONE OAK MEDICAL

oneoakmedical.com

Last Name:	**First Name:**	**MI:**
Date of Birth:	**Gender**	Marital Status
Address:	City:	State: Zip:
Home Phone	Cell Phone	
Work Phone	E Mail Address	
Primary Care Provider:	Primary Care Provider Phone	
Occupation	Employer	
Employer Address	**Employer Phone Number**	
Who Referred you here?	Referring Provider Phone	
Pharmacy Name	Pharmacy Phone	
Emergency Contact	Relationship	
Emergency Contact Phone		
Preferred Language:	**Interpreter Needed:** Yes: __ No: __	

Tell us why you came to see us today

Reason	Date this Began

Is this visit through Medical Insurance /MVA/WC or Self Pay_____

Workers Comp. Information	**Motor Vehicle Information**
Employer	Insurance Co.
Phone	**Claim Number**
Bill to?	**Claims Adjuster**
Claim #	**Date of Accident**

Primary Insurance Information	**Secondary Insurance**
Name	Name
Policy #	Policy #
Subscriber DOB:	Subscriber
Relationship	Relationship
Subscribers Social Security #	Subscribers Social Security #

Attorney Name: Phone Number:

DESIGNATION OF RELATIVES, FRIENDS AND OTHER CAREGIVERS FOR HEALTHCARE DISCLOSURE

I agree that One Oak Medical Group may disclose certain healthcare information to persons involved with my healthcare decisions o r payment. I designate the following person(s) listed below as being involved with my healthcare for the purpose of One Oak Medica l making limited information disclosure for the above purpose. I UNDERSTAND I AM NOT REQUIRED TO LIST ANYONE. I also understand I may change the designees in writing at any time.

Print Name _____ Relationship _____ Last 4 Digits of SS#_____

Patient/Parent or Guardian Signature X_____**Date** X_____

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Thank you for choosing One Oak Medical Group. We are committed to providing our patients with top notch and affordable healthcare. Because you may have questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it, ask for clarification if needed, and sign in the space provided.

MEDICAL CONSENT

The undersigned consents to any x-ray examination, laboratory procedure(s) and medical treatment rendered to the patient under the general or special supervision of, or upon the advice of medical provider at One Oak Medical Group.

_____**(Initial)**

RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement to One Oak Medical Group the patient's medical records may be disclosed to any person or corporation (or any agent of such person or corporation) which is or may be liable for all or any portion of changes by One Oak Medical Group, (including but not limited to insurance companies, health care service plans, worker's compensation carriers and employers.)

_____**(Initial)**

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my insurance benefits to One Oak Medical Group. Payment shall not exceed the group's regular charges for treatment. I understand that One Oak Medical is an Out of Network provider and are not contracted with my insurance aside from Medicare. I am financially responsible to the medical group for charges not covered by this authorization.

_____**(Initial)**

FINANCIAL AGREEMENT

In consideration of the service to be rendered to the patient, the undersigned agrees, whether they sign as patient, agent, or as a financially responsible party, to pay all charges for patient's care to One Oak Medical Group in accordance with the medical groups current rates and terms.

_____**(Initial)**

The undersigned certifies that they have read the foregoing, received a copy of the same and accepts all its terms and conditions.

Patient Signature or Patient's Agent or Representative_____

Patient Name (Print)X_____ **Date**X_____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____

A copy of this singed, dated document shall be as effective as the original.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility.

MY SIGNATURE WILL ALSO SERVICE AS A PHI DOCUMENT RELEASE SHOULD ONE OAK MEDICAL NEED TO REQUEST AND OR OBTAIN MY RECORDS OR RADIOGRAPHS FROM ANY OTHER ATTNEDING DOCTORS/FACILITES IN THE FUTURE OR CONSENT FOR DATA TO BE EXCHANGED ELECTRONICALLY BETWEEN PROVIDERS/HOSPITALS.

_____ Please ***print*** your name

_____ Please ***sign*** your name

_____ Legal Representative

_____ Relation to patient

Your comments regarding Acknowledgement or Consents

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION and INFORMATION ABOUT MY HEALTH** VIA

Choose Only One Point of Contact

Home Telephone Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only

Cell Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only
_____ OK to send a text with detailed information

Work Telephone Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave a message with call back numbers only

Other (please describe) _____

Signature of OOM Staff Member _____ Date:_____

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Allergies/Drug Reactions:_____

Do you currently use any form of tobacco? Yes/No
If you previously smoked, how long did you smoke for?_____ **When did you quit?**_____

Previous surgeries/hospitalizations? Please list dates:_____

_____

Are you currently taking medication, including over the counter or herbal medication? If yes, Please list

_____

GENERAL SKIN

___ Recent weight gain/loss
___ Fatigue
___ Sweats easily
___ Night Sweats
___ Rash or itching/eczema Change in skin color
___ Change in hair / nails
___ Non-healing sores

Other:_____

MUSCULOSKELETAL

___ Low back pain
___ Mid back pain
___ Upper back pain
___ Neck pain
___ Shoulder pain R / L
___ Arm problems R / L
___ Leg problems R / L
___ Hip pain R / L
___ Foot problems R / L
___ Painful, stiff, or swollen joints
___ Weak muscles
___ Joint replacement
___ Fractured bones

Other:_____

VISION

___ Glaucoma
___ Eye disease or Injury
___ Cataracts

Other:_____

NOSE, & THROAT/EARS

___ Tinnitus (Ringing in ear)
___ Migraines / Headaches
___ Dizziness
___ Hearing loss
___ Allergies / Sinusi
___ Bleeding gums or mouth sores ___ Dental problems
___ Swollen throat or lymph glands ___ Jaw Pain / TMJ

Other:_____

CARDIOVASCULAR

___ Chest pain / tight chest
___ Heart attack
___ Hypertension (high blood pressure)
___ Hypo-tension (low blood pressure)
___ Edema
___Stroke / Concussion

Other:_____

GENITOURINARY

___ Sexual Dysfunction
___ Incontinence / Bed Wetting
___ Frequent Urination
___ Kidney Stones

Other:_____

RESPIRATORY

___ Difficulty breathing
___ Persistent cough
___ Asthma
___ Bronchitis
___ COPD
___ Emphysema

Other:_____

PSYCHOLOGICAL

___ Anxiety
___ Nervousness
___ Depression
___ Sleep Problems
___ Memory Loss / Confusion
___ Easily stressed

Other:_____

GASTROINTESTINAL

___ Loss of appetite / Heavy appetite
___ Cravings
___ Change in bowel movements
___ Abdominal Pain / Ulcer / Colitis
___ Frequent Diarrhea / Constipation

Other:_____

REPRODUCTIVE

___ Breast pain / lump
___ Painful or irregular menses
___ Infertility
___ Prostate problems
___ Erectile dysfunction
___ Cramps
___ Menopause
___ # of pregnancies
___ # of miscarriages
___ Age of 1st menses
Do you use birth control? Y/N
Date of last menses:

The above information is true and accurate to the best of my knowledge

*Patient Signature*_____ *Date:*_____