Patient Medical History Form: (Child under age 16)

Name:_____ Date of birth:_____

Reason for the visit:_____

Current Medications – both prescription and over the counter

_____ _____ _____

_____ _____ _____

_____ _____ _____

List the reasons for taking listed medications, and/or any other medical problems

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any drug allergies

_____ _____ _____

List any surgeries and year of surgery if known.

_____ _____ _____

_____ _____ _____

Is the patient's father alive? ___no ___yes. List any medical problems they have/had:

_____

Is the patient's mother alive? ___no ___yes. List any medical problems they have/had:

_____

Do any siblings have any medical problems? ___no ___yes: If so, please list:

_____

Is there any passive smoke exposure? ___no ___yes Daycare? ___no ___yes

Caffeine use? ___no ___yes Pets in the home? ___no ___yes

Was a hearing screen passed at birth? ___no ___yes

Complications with pregnancy or delivery? ___no ___yes:
list:_____admission to NICU ___no ___yes

Any complications from anesthesia? ___no ___yes.

Family history of bleeding disorder? ___no ___yes.

Parent or guardian signature:_____

ENT & Allergy Patient Demographics

Date completed:____/____/_____ Date of birth:____/____/_____ Social Security Number:_____

Patient Name:_____ Gender:_____ Marital Status: S M D W

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email:_____ Activate Patient Portal: ____yes ____No

Preferred Language:_____

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact:_____ Phone number:_____

Employer:_____

Employer address:_____

Work Phone: (_____)_____-_____ Occupation:_____

Primary Insurance:_____ Policy Holder Name:_____

Policy Holder date of birth: ____/____/_____ Policy Holder social Security number:_____

Policy Holder Address (If different than patient)

_____

Patient's relationship to the insured: _____spouse _____child _____Other (specify)_____

Secondary Insurance:_____ Policy Holder Name:_____

Policy Holder date of birth: ____/____/_____ Policy Holder social Security number:_____

Policy Holder Address (If different than patient)

_____

Patient's relationship to the insured: _____spouse _____child _____Other (specify)_____

If the patient is a minor - Responsible Person's Name:_____

Date of birth: ____/____/_____ Social Security number:_____

Address if different from patient

address_____

Relationship to the Patient: _____spouse _____child _____Other (specify)_____

Pharmacy Name:_____ Phone (if known) (____) _____-_____

Address if known, or major cross streets so we can pull from out database

_____

Financial Policy & Consent for Treatment Agreement

R. Jeff Goodell
1621 A Midtown Place
Midwest City, OK 73130

Patient Name:_____

I. Consent to Treatment

I hereby give my consent for medical treatment by the physician or staff under the direction of Dr Goodell.

_____ _____
Patient or Guardian Signature Date

II. Payment Policy

I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance without limitation, including: deductibles, co-payments, co-insurance, or other amounts unpaid by my insurance. Dr. Goodell files claims for Medicare, as well as any other private insurance plans where we are a participating member. Claims will not be filed with insurance carriers that are not contracted with our office. If you plan to pay by check and it is dishonored, a processing fee of $25.00 will be assessed. I understand that this office may assess a $25.00 fee for missed appointments without a 24 hour notice.

_____ _____
Patient or Guardian Signature Date

III. Assignment of Benefits

I agree to assign to Dr. Goodell and/or his office, all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

_____ _____
Patient or Guardian Signature Date

IV. Authorization for Release of Medical Information

I hereby authorize Dr. Goodell's office to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider.

I give Dr. Goodell's office permission to discuss my protected health information with the following persons:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

V. I understand that I may rescind or modify this permission at any time. Such changes must be in writing to this office

_____ _____
Patient or Guardian Signature Date

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

R. Jeff Goodell, D.O.
1621 A Midtown Place
Midwest City, OK 73130
Phone: 405-736-9300 Fax: 405-736-9301