RHEUMATOLOGY ASSOCIATES OF OKLAHOMA

6516 N. Olie, Suite G • Oklahoma City, OK 73116
10001 S. Western, Suite 202 • Oklahoma City, OK 73139
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Phone 405.608.8060 • Fax 405.608.8070

IT IS THE POLICY OF THIS OFFICE THAT ALL PAYMENTS ARE DUE AT THE TIME OF VISIT!

PATIENT INFORMATION

Patient's Full Name _____ Social Security Number _____

Date of Birth _____ Age _____ Sex ◉ Male ○ Female

Race _____ Ethnicity ○ Hispanic ○ Non - Hispanic Preferred Language _____

Marital Status ◉ Single ○ Married ○ Divorced ○ Widowed

Patient's Current Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ E-mail _____

EMERGENCY CONTACT INFORMATION

Spouse's Name _____ Phone # _____

Emergency Contact • Next of Kin

Name _____ Phone # _____ Relation _____

INSURANCE INFORMATION

Primary Insurance Coverage _____ Policy ID # _____

Cardholder's Name _____ D.O.B. _____ SS# _____

Cardholder's Employer _____

Secondary Insurance Coverage _____ Policy ID # _____

Cardholder's Name _____ D.O.B. _____ SS# _____

Cardholder's Employer _____

Is this a Secondary Insurance for all family members? ○ Yes ○ No

If NO, Please Explain _____

MEDICATIONS AND ALLERGIES

Please answer every question

Patient Name:_____Date of Birth: _____

ALLERGIES

Please indicate if you have allergies to any of the following:

☐ I HAVE NO KNOWN ALLERGIES

☐ Sulfa Drugs
☐ Codeine / Codeine Derivatives
☐ Morphine Derivatives
☐ Erythromycin
☐ Penicillin
☐ Latex
☐ Adhesive Tape / Bandages
☐ Betadine / Iodine
☐ Seasonal Allergies (Hay Fever)

Please list any additional allergies you have. If possible, include your reactions.
(e.g., hives, rash, itching, nausea, diarrhea, fainting, headaches, shock, shortness of breath, etc.)

Name	Reaction

MEDICATIONS

What medications are you currently taking?
(Include prescriptions, over the counter medications, herbal supplements and vitamins.
e.g., Aspirin, Motrin, Vitamin E, St. John's Wort, etc.)

☐ **I AM NOT CURRENTLY TAKING ANY MEDICATIONS** (prescription or over the counter)

Name	Dosage	Frequency

Name	Dosage	Frequency

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize _____
Name of Person/Organization Disclosing PHI

to release the following information to Rheumatology Associates of Oklahoma 6516 N. Olie, Suite G Oklahoma City, OK 73116
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between_____ and _____

☐ Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

Chart No. _____

Rheumatology Associates of Oklahoma
Authorization to Release Information via phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of Rheumatology Associates of Oklahoma regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____ Cell phone: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

Rheumatology Associates of Oklahoma, LLC STAFF ONLY:

Documented by:

_____ _____
Initials Date