

Medical History Form - Adult or child over 16 years of age

Name: _____ Date: _____ Date of Birth: _____

Reason for the visit today: _____

Current Medications and why you take them. Include over the counter meds like aspirin (use back of paper if you need more space)

Medication:

Reason for taking:

Drug Allergies:

List any head and neck surgeries:

Is the patient's father alive: ____no ____yes. List any medical problems they have or had:

Is the patient's mother alive: ____no ____yes. List any medical problems they have or had:

Do siblings have any medical problems: ____no ____yes. If so, please list:

Do you smoke? ____no ____yes. Packs a day? ____ Total years smoked? ____

Do you use drugs recreationally? ____no ____yes. If yes, please list: _____

Do you drink alcohol? ____no ____yes. If yes, how much and how often? _____

Patient/guardian signature _____ Date: _____



Patient Registration- Dr. J. Goodell – Dr. L. Smith

Patient Information

Name: _____ Today's Date: ___/___/___

Sex: _____ Age: _____ Birthdate: ___/___/___ Social Security #: _____ - _____ - _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Mobile Phone #: _____

Marital Status (Circle One): Married Single Divorced Widowed Separated Domestic Partner

Email address: _____ Would you like access to your patient portal? ___yes ___no

Employer: _____ phone: _____

Emergency Contact

Name: _____ Phone: _____ Relationship to Patient: _____

For minors:

Guardian/Responsible Party: _____ Relationship to Patient: _____

Birthdate: ___/___/___ Social Sec #: _____ Phone: _____

Address (if different from patient's): _____

Pharmacy(*important*)

Name, Location: _____

Physician information

Primary Care Physician's Name: _____

Referring Physician's Name" _____

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