Medical History Form - Child under 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:

____

Smoke exposure ____no ____yes. Daycare? _____no ____yes Caffeine use: ____no ____yes.

Pets in the home: _____no ____yes Passed a hearing screen at birth? _____no ____yes

Complications with pregnancy? ____no ____yes If yes, please list:______________________

Family history of anesthesia problems:____

Family history of bleeding disorders:____

Parent/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