436 S. Mustang Rd.
Yukon, OK 73099

WILSON MEDICAL

4200 Carriage Way
Weatherford, OK 73096

New Patient Information

Please print neatly and fill in all blanks

Patient's Legal Name: ______________________________
(first) (middle) (last)

Date of Birth: ________/________/________ Age: ___________ Social Security No. ________ _/________ /_________

Circle One: Single Married Divorced Separated Other: ______________

Patient's Address: ______________________________
(street address) (city) (state) (zip)

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Employer: ____________ Email Address: ____________

Primary Care Physician: ____________ Phone Number: ____________

Referring Physician: ____________ Phone Number: ____________

Name of Primary Insurance Company: ____________

Name of person who carries insurance: ____________ Relationship to Patient: ____________

Carrier's DOB:______/______/______ Carrier's SSN: ______/______/______ Carrier's Employer: ____________

Secondary Insurance Company (if applicable) ____________

Name of person who carries insurance: ____________ Relationship to Patient: ____________

Carrier's DOB:______/______/______ Carrier's SSN: ______/______/______ Carrier's Employer: ____________

Spouse's Name: ____________ Phone: ____________

Nearest relative not living with you: ____________ Relationship: ____________ PH: ____________

If patient is a minor, please list both parents information:

Mother: ____________ Employer: ____________ PH: ____________

Father: ____________ Employer: ____________ PH: ____________

I hereby authorize my insurance benefits to be paid directly to the facility and the physician. I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge and agree and received a copy of the HIPPA Privacy Notices.

____
(Signature) (Date)

WILSON MEDICAL

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the patient to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIMS

I hereby authorize the physician(s) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of the physician's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, welfare funds, the Social Security Administration or its intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release TPG, its agents and it employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit. I understand I am financially responsible for charges not covered by this assignment.

I understand a photocopy of this document is as valid as the original.

Print Name ____

____ Date:________________

Patient's Signature

____ Date:________________

OR Responsible Party Signature (parent of minor, etc)

WILSON MEDICAL

Authorization to Release Information via phone/Family/Friends

Print your name: ____ DOB: _____________

I hereby authorize confidential communications from the physicians or staff of this office regarding my health care, lab work, test results, treatments, appointments, prescriptions, etc… to be received at any of the phone 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: __________________ Cell phone: ________________ Other: ________________

I authorize the following individuals (spouse, family member, and/or friend) to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested. **(Leave blank if you do not authorize any other individual to access your protected health information.)**

Name: ________________________________ Relation: ___________________________

Name: ________________________________ Relation: ___________________________

Name: ________________________________ Relation: ___________________________

Name: ________________________________ Relation: ___________________________

Below is the pharmacy and pharmacy phone number that I will us for all prescriptions : (for your convenience phone books are located throughout the lobby.)

Pharmacy Name : _______________________________ Pharmacy Number: _______________

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

____ ____________________

Patient Signature Date

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. **Rachelle Wilson, D.O.,** has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

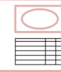
______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Print Name of Patient	Print Name of Parent or Guardian

Dated:________________________

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Medications and Allergies

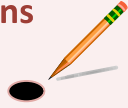
Please answer every question.



STAFF: All items on this page must be be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

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
- ◯ Iodine
- ◯ Betadine
- ◯ Seasonal Allergies (Hay Fever)

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

PHARMACY

Please list the pharmacy you would like us to use when calling in your prescriptions (if needed):

Pharmacy: ______________________________

Location: ______________________________

Copyright © PatientLink MedsAllergies Form (Rev. 11/26/2012)