COVID Infusion Center

New Patient Information

Please print neatly and fill in all blanks

1728 Professional Circle
Yukon, OK 73099

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 parent's 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)

PAST MEDICAL HISTORY (check all that apply)

□Aids/HIV	□Allergies/Hay Fever	□Anemia	□Arthritis
□Asthma	□Bladder Dysfunction	□Bowel Irregularity	□Cancer: _____
□Chest Pain/Angina	□Congenital Heart Disease	□Depression	□Diabetes
□Dizziness/Fainting	□Emphysema	□Epilepsy	□Glaucoma
□Gout	□Headaches	□Hearing Loss	□Heart Attack
□Heart Murmur	□Heart Palpitations	□High Blood Pressure	□High Cholesterol
□Liver Disease	□Menstrual Dysfunction	□Positive TB Screening	□Blood Transfusion
□Prostate Disease	□Rheumatic Fever	□Scarlet Fever	□Sexual Dysfunction
□Shortness of Breath	□Stroke	□Thyroid Disease	□Ulcer
□Venereal Disease	□Other: _____		

FAMILY HISTORY-Has any blood relative had any of the following? Check all that apply and list which family member.

□Alcoholism_____	□Allergies_____	□Alzheimer's Disease_____
□Anemia_____	□Asthma_____	□Bleeding Tendency_____
□Blindness_____	□Cancer (type) _____	□Diabetes_____
□Epilepsy_____	□Hearing Loss_____	□Heart Disease_____
□High Blood Pressure_____	□High Cholesterol_____	□Kidney Disease_____
□Memory Loss_____	□Mental Health Disorder_____	□Neurological Disorder_____
□Osteoporosis_____	□Stroke/CVA_____	□Tuberculosis_____
□Other_____		

Medications (Prescribed and/or Over the Counter)

☐ **I am currently not taking any medications.**

Name	Dose	Frequency

Allergies (List Drug and other allergies)

☐ **No Known Drug Allergies**
☐ **No Known Allergies**

Name	Reaction