Diana O'Connor, DO

Patient Information Sheet

Name:______________________________ Social Security#:________-________-________

Address:______________________________ Apt___ City:____________State:________ZIP:__________

Home Phone:(____) ______-_____Cell Phone:(____) ______-________ Work Phone(____) ______-______

DOB: ____/____/______ Sex: ☐M ☐F _S_M_D_W Spouse's name ____________________

Employer________________Position:________________ Email:____________________

Parents name for minor patient ____

Primary Insurance

*******************Even though a copy was made of your card, please fill out all fields*******************

Name of Insurance:____________________________________

Name of Policy Holder:____________________ Relationship:__________ DOB:__________

Holder SS#:________-________-________ Policy ID:________________ Group :__________

Policy Holder Employer:__________________________________

Secondary Insurance

Name of Insurance:________________________ Name of Policy Holder:____________________

Relationship:______________ DOB:____/____/______ Holder SS#:________-________-________

Policy ID:________________Group #:____________________

EMERGENCY CONTACT NAME____

RELATIONSHIP TO PATIENT____

PHONE #(_____) __________-____________

Authorizations

A: BENEFITS TO PHYSICIAN: I hereby authorize payments directly to the physician of the surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.
B: RELEASE OF INFORMATION: I hereby authorize releases of information for insurance claim purposes. Photostat of above is valid as the original. I understand all of the above hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant requests for authorizations.

Signed: ______________________________ **Date:** _____/_____/________

Diana O'Connor, DO

Patient Information Sheet

Name:____ DOB:______/________/________

Medication History

Allergies: ____

PLEASE LIST **CURRENT** MEDICATIONS YOU ARE TAKING INCLUDING OVER THE COUNTER OR WRITE N/A

DATE:	Medication:	Dosage:	Frequency:

PHARMACY NAME, ADDRESS, AND PHONE NUMBER:

____

____

Please list any past and present medical history. : (*please list Diabetes, Heart Disease, Pneumonia, Asthma, etc.*)

____

____

____

____

Diana O'Connor, DO

Patient Information Sheet

Medical History

Name:______________________________ DOB:______/________/__________

Past Medical History

List Childhood Diseases: (*Mumps, Measles, Chickenpox, Scarlet Fever etc.*)

Surgical History: *(please list any and all surgeries)*

Any Serious Injuries or Accidents? ☐ No ☐ Yes

Explain:____

____

____

LAST MAMMOGRAM DATE & LOCATION:(WOMEN ONLY 40)______________________________

LAST PAP SMEAR DATE & LOCATION: (WOMEN ONLY 21+)______________________________

LAST BONE DENSITY DATE & LOCATION:(65+)______________________________

LAST COLONOSCOPY DATE & LOCATION: (45+):______________________________

LAST LABS DATE & LOCATION:______________________________

LAST EKG DATE AND LOCATION:______________________________

LAST DIABETIC EYE EXAM:(DIABETIC PATIENTS ONLY):______________________________

COVID VACCINE(S) DATE(S):______________________________

☐MODERNA ☐PFIZER ☐J&J

FLU SHOT DATE & LOCATION:______________________________

Diana O'Connor, DO

Name:____ DOB:________/__________/___________

Social History

☐Single ☐Married ☐Widow(er) ☐Divorce Number of children?______________________

Smoke: ☐Yes ☐No If YES, Number of Packs a Day:______ Number of years ?_______________

Alcoholic Beverages: ☐Yes ☐No If YES, approximately how much?______________________________

History of Substance Abuse: ☐Yes ☐No

Family History

Mother: ☐Living ☐ Deceased Age:________ If deceased,
cause:____
Father: ☐Living ☐ Deceased Age:_________ If deceased,
cause:____

SIBLINGS:
HOW MANY BROTHERS?___________
HOW MANY SISTERS?_____________
Are there any Diseases that run in your family, such as:
Cancer (if so, what type):____________________ High blood pressure:____________________________
Diabetes:___________________________________ Heart Disease:____________________________
Kidney disease:_________________________ Stroke:______________________

Diana O'Connor, DO

Office Policies Regarding Payments

&

Insurance Claim Filing

Name:____ DOB:______/________/__________

- We are committed to providing you with the best possible medical care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our office policy.

- If you have insurance, *PLEASE* have your insurance card with you at the time of your visit. If for some reason we cannot verify coverage & benefits or if you *DO NOT* have your insurance card with you, then YOU will be responsible for all charges incurred at the time of the service. Our filing of your claim is courtesy to you.

- Copayments and deductibles are due at the time of your service. We accept payment in the following forms: Cash, Personal Checks, Visa, and MasterCard. We do *NOT ACCEPT* post-dated checks.

- We accept Medicare Assignment, which means the patient is responsible only for the percentage Medicare allows, but did not pay. We will file Medicare claims for you.

- Our Payment Policy is for other family members bringing in a minor as follows: The person accompanying the minor is responsible for paying the account. If a legal document is involved stating another individual is responsible for paying medical costs, that document is between those individuals involved, and *DOES NOT* invoice our office. You will be given an itemized statement from which *YOU* may be reimbursed. Please be advised that Oklahoma Law states any medical information requested from a non-custodial parent must be given upon demand. Our office abides by this.

- In the event that a patients' account is turned into collections, the patient will be responsible for the amount turned plus any and all collection fees, which could also include attorney fees.

Diana O'Connor, DO

Name:______________________________________ DOB:______/________/__________

NO SHOW POLICY** IT IS VITAL THAT YOU KEEP SCHEDULED APPOINTMENTS*****

1ST- A REMINDER WILL BE SENT OUT
2ND - A CHARGE OF $50 & REMINDER SENT OUT STARTING 4/1/2021
3RD -A CHARGE OF $50 & WE TERMINATE YOU AS A PATIENT STARTING 4/1/2021

Consent to the Use & Disclosure of Health Information
For Treatment, Payment of Health Care Operations

Please list the people you will allow our office to disclose information to in the case of Emergency & You are unable to communicate

NAME:____ PHONE #(____)______-______

RELATIONSHIP TO PATIENT:________________________________

NAME:____ PHONE #(____)______-______

RELATIONSHIP TO PATIENT:________________________________

NAME:____ PHONE #(____)______-______

RELATIONSHIP TO PATIENT:________________________________

I request the following restrictions to the user and/or disclosure of my Health Information.____________________

____

X   /   /
____
Signature of Patient or Legal Representative **Date**

Diana O'Connor, D.O.

9809 S. Pennsylvania
Oklahoma City, OK 73159
405-692-1557 Fax: 405-692-4490

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE ______________

PATIENT NAME: ____

DATE OF BIRTH: ______________ SS#: ______________________

I HEREBY AUTHORIZED THE RELEASE OF MY MEDICAL RECORDS

FROM:	TO:
______________________ INSTITUTION	______________________ INSTITUTION
______________________ ADDRESS	______________________ ADDRESS
______________________ CITY, STATE ZIP	______________________ CITY, STATE ZIP
______________________ (AREA) PHONE	______________________ (AREA) PHONE

MEDICAL RECORDS REQUESTED ARE: _____ALL _____X-RAY _____LAB

SERVICE DATES FROM ____________________ TO ____________________

I ACKNOWLEDGE THAT MY RECORDS MAY CONTAIN REFERENCES TO REPORTABLE COMMUNICABLE OR VENEREAL DISEASES WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) AND MAY INCLUDE DRUG, ALCOHOL, OR PSYCHOLOGICAL INFORMATION. BY THIS ACKNOWLEDGEMENT, I RELEASE THE ABOVE NAMED INSTITUTION FROM ANY LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THIS RELEASE AUTHORIZATION AND WAIVER ALL RIGHTS AND PRIVILEGES ALLOWED BY LAW RELATING TO DISCLOSURE OF CONFIDENTIAL INFORMATION, DEFAMATION, AND INVASION OF RIGHTS OF PRIVACY.

I REALIZE BY THE RECEIPT OF THESE RECORDS THAT I AM ACCEPTING RESPONSIBILITY FOR THE PROTECTION OF MY OWN RIGHT OF MEDICAL RECORD CONFIDENTIALITY.

______________________________________ ______________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP