Name: ______________________________
DOB: ____________

NRHS Patient History

Preventive Health

Immunization	**Date Performed**	
Annual Lab (In the past year)		
Influenza Vaccination		
Prevnar (1st Pneumonia shot)		
Pneumovax(2nd Pneumonia shot)		
Tetanus Vaccination		
TDAP		
Zostavax (Shingles vaccine)		
Screening Test	**Date Performed**	**Results** (Normal/Abnormal)
Colonoscopy		
Mammogram		
PAP		
PSA (Prostate)		
Chest X-Ray		
Chest CT (Lung Scan)		
Dexa Scan (Bone Scan)		

Medications

Please list all medications you are taking currently, including over the counter and herbal remedies. Please include dosage and number of times a day the medication is taken if known.

Medication Name:	**Dosage (mg, cc, etc)**	**Frequency (how often)**

Pharmacy

____

NORMAN REGIONAL Health System

Name: ______________________________________

DOB: ______________

NRHS Patient History

Past Medical History

Please mark any current or previous illnesses or health problems.

___ Anxiety
___ Anemia
___ Arthritis
___ Asbestos Exposure
___ Asthma
___ Bipolar Disorder
___ Bleeding Disorder
___ Blood Clots
___ COPD/Emphysema
___ Chronic Pain related to ____________________
___ Dementia
___ Depression
___ Degenerative Joint Disease
___ Diabetes Mellitus
___ Heart Attack
___ Heart Disease
___ Heart Rhythm Problem
___ Hepatitis
___ High Cholesterol
___ High Blood Pressure
___ HIV
___ Kidney Disease
___ Lupus
___ Parkinson's Disease
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Schizophrenia
___ Stroke
___ Thyroid Disease
___ Tuberculosis (positive PPD)
___ Ulcers

Other History/Details ____
____
____

Allergies

Please list all food and drug allergies:

____ ____
____ ____
____ ____
____ ____
____ ____

Surgical History / Major Diagnostic Procedures

___ Appendectomy
___ Back Surgery
___ Bariatric (Weight Reduction)
___ Breast (was cancer involved____)
___ C-Section
___ Gall Bladder
___ Lung Biopsy
___ Lung Resection
___ Heart Catheterization
___ Heart Bypass Surgery
___ Prostate Surgery
___ Hysterectomy (was cancer involved____)
___ Tonsillectomy
___ Tubal Ligation
___ Tumor Removal
___ Vasectomy

Other History/Details ____
____
____

Hospitalizations

____ ____
____ ____
____ ____
____ ____
____ ____

Name: ______________________

DOB: ____________

NRHS Patient History

Family History

Are you adopted? ___Yes ___No

	Father	Mother	Siblings	Paternal GF	Paternal GM	Maternal GF	Maternal GM
Living							
Deceased							
Diabetes							
Hypertension							
Heart Disease							
Mental Illness							
Cancer (type)							
Stroke							
Thyroid Disease							
High Cholesterol							
Blood Clots							
Lung Disease							
Tuberculosis							
Mental Illness							
Headaches							
Seizure							
COPD/Emphysema							
Other (specify)							
Unknown							

Social History

Tobacco Use:

___ Never smoked

___ Former smoker: How long has it been since you quit?
___ Less than 1 year ___ 1-5 years ___ 5-10 years ___ 10-20 years ___ 20+ years

___ Current smoker: If yes, how often do you smoke?
___ Daily ___ Frequently ___ Rarely
How soon after you wake up do you smoke?
___ Within 5 minutes ___ Within 30 minutes ___ Within 60 minutes ___ 60+ minutes
How many cigarettes do you smoke in 24 hours?
___ 5 or less ___ 6-10 ___ 11-20 ___ 21-30 ___ 31+
Do you use other forms of tobacco?
___ Cigar ___ Pipe ___ Chewing tobacco ___ Vapor
Are you interested in quitting?
___ Ready to quit ___ Thinking about quitting ___ Not ready to quit

NORMAN REGIONAL
Health System

Name: ______________________________
DOB: ____________

NRHS Patient History

Social History Continued

Recreational Drug Use:

___ None ___ Marijuana ___ Cocaine ___ Heroin ___ Prescription Pain Pills ___ Methamphetamines ___ Other

Alcohol Use:

Did you have a drink containing alcohol in the past year?

___ No

___ Yes: If yes, how often did you have a drink containing alcohol in the past year?
___ Monthly or less ___ 2-4 times a month ___ 2-3 times a week ___ 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year?
___ 1-2 drinks ___ 3-4 drinks ___ 5-6 drinks ___ 7-9 drinks ___ 10+ drinks
How often did you have 6 or more drinks on one occasion in the past year?
Never Less than monthly Monthly Weekly Daily or almost daily

Caffeine:

___ Coffee ___ Soda ___ Energy drinks ___ Other ____________ How many daily? ____________

Do you take daily aspirin? ___ Yes ___ No

Children:

___ Yes ___ No

Are you claustrophobic? ___ Yes ___ No

Exercise:

___ Daily ___ Occasionally ___ Rarely ___ Never
What kind of exercise? ______________________________

Marital Status:

___ Single ___ Married ___ Divorced ___ Widowed ___ Other

Do you have metal in your body? ___ Yes ___ No

Occupation:

____

Pets:

___ Cats ___ Dogs ___ Birds ___ Horses ___ Other ______________________________

Travel Outside US:

___ Yes ___ No If yes, when? ______________________________

Patient Name: ____________________________
Date of Birth: ____________________________

REVIEW OF SYSTEMS

(Please Check All That Apply)

GENERAL: ____Fatigue ____Fever ____Change in appetite

SKIN: ____Rash

HEENT: ____Nasal congestion ____Snoring ____ Head trauma ____Allergies ____Hoarseness ____Ringing in ears ____Dizziness ____Loss of hearing

EYES: ____Blurring of vision ____Double vision ____Glaucoma ____Other vision changes

RESPIRATORY: ____Chest congestion ____Cough ____Wheezing

NEUROLOGICAL: ____Restless leg syndrome ____Weakness ____Numbness in legs ____Numbness in hands ____Memory loss ____Migraines ____Seizures ____Tremor ____Vertigo

CARDIO: ____Shortness of breath

GASTRO: ____Abdominal pain ____Constipation ____Diarrhea ____Difficulty swallowing ____Nausea ____Vomiting

MUSCULOSKELETAL: ____Joint pain ____Joint stiffness ____Joint swelling ____Muscle weakness

PSYCHIATRIC: ____Psychosis ____Difficulty concentrating ____Depression ____Stress ____Anxiety

ENDOCRINE: ____Cold intolerance ____Excessive thirst

UROLOGIC: ____Spontaneous loss of urine ____Frequent nighttime urination ____Frequent urination

Check Here If All Above Are Negative: ______

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. PATIENT INFORMATION (PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth
Address	City / State / Zip
Area Code & Telephone Number	

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information for reasons in addition to those already permitted by law.

A. PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE MY INFORMATION:

(Name, Address, Phone & Fax) **Relationship** **Purpose**

____

____

____

____

B. INFORMATION TO BE SHARED:

1. CHECK ONE OR MORE OF THE BOXES BELOW:

☐Entire Medical Record (includes all records except Psychotherapy Notes)

☐Psychotherapy Notes

☐Mental Health Records	☐History and Physical	☐Operation Report(s)
☐Pathology Report	☐Consultation Report(s)	☐Discharge Summary
☐Progress Notes	☐Laboratory Report(s)	☐Radiology Report(s)
☐EKG Reports	☐Radiology Films	☐Alcohol or Drug Abuse Records
☐Physician's Orders	☐Other	

2. COVERING SERVICES BETWEEN ____________AND____________ (Insert either date(s) or "all")

IV. EXPIRATION & REVOCATION

A. THIS AUTHORIZATION WILL EXPIRE: (MUST CHOOSE ONE)

☐ 3 years after last office encounter ☐ Other (insert date or event): ______________________

B. RIGHT TO REVOKE

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. ACKNOWLEDGEMENTS

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I understand «RendPrFName» «RendPrLName» «RendPrSuffix», as a member of Oklahoma Physician Health Exchange (OPHX), may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.

6. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. SIGNATURE

This document must be signed by the individual or the individual's legal representative.

______________________________	______________________________
Signature (Patient or Legal Representative)	**Date**
______________________________	______________________________
Printed Patient or Legal Representative Name	**Capacity of Legal Representative (if applicable)**

Norman Regional Health System's Owned Clinics

Blanchard Family Medicine	Neurology Associates
Diabetes & Nutrition Education	Newcastle Family Medicine
Endocrinology Associates	Norman Heart & Vascular
Family Medicine – Findlay	NRHS HPX Family Med – Livingston
Family Medicine – Moore	NRHS Internal Medicine Assoc P&S
Family Medicine – Noble	NRHS Journey Clinic
Family Medicine – South OKC	NRHS Surgical Associates
Family Medicine at Doctor's Park	Oklahoma Sleep Associates
Heart Plaza Imaging	Primary Care – Waterview
Infectious Disease	Primary Care – West Norman
Miles Family Medicine	Pulmonary Clinic at Medical Plaza
Moore Care for Women	Rheumatology Associates
Moore Pediatrics	The Pulmonary Clinic

PATIENT REGISTRATION

Last Name ____________ First Name ____________ MI ______

Address ____________ City ______ State ____ Zip ______

Home Phone ______ Cell Phone ______ Work Phone ______

Physician You Normally See ______ Physician Who Referred You ______

Date of Birth ______ Sex M F Marital Status ______ Social Security No ______

Employer ____________ City ______ State ____ Zip ______

RESPONSIBLE PARTY OR INSURED (If different than patient)

Guarantor Name ____________ Phone ______ Cell ______

Address ____________ City ______ State ____ Zip ______

Social Security No ____________ Date of Birth ______

Employer ______ City/State ______ Zip ______ Relationship to Patient ______

INSURANCE INFORMATION

Primary Insurance ____________ Group ______

Insurance Address ____________ Policy ID ______

Insured's Relationship to Patient ______ **IF NOT SELF, FILL OUT INFORMATION FOR RESPONSIBLE PARTY ABOVE**

Secondary Insurance ____________ Group ______

Insurance Address ____________ Policy ID ______

Insured's Name ____________ Relationship to Patient ______

Insured's Date of Birth ______ Insured's Employer ______

Tertiary Insurance ____________ Group ______

Insurance Address ____________ Policy ID ______

Insured's Name ____________ Relationship to Patient ______

Insured's Date of Birth ______ Insured's Employer ______

EMERGENCY CONTACT (Not living with patient)

Name ____________ Relationship ______

Home Telephone No ______ Work Telephone No ______

OTHER INFORMATION

Primary Pharmacy ______ City/State ______ Zip ______

Secondary Pharmacy ______ City/State ______ Zip ______

Your Email ____________ Can we leave a message on your home phone? Y N

Can we leave a message on your cell phone? Y N

Race ______ Ethnicity Hispanic or Non-Hispanic ______ Primary Language ______

5/2016

Name ____ DOB: _____________

AUTHORIZATIONS

CONENT FOR TREATMENT: I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

RELEASE OF INFORMATION: I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse, communicable disease or non-communicable disease) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare/Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

ASSIGNMENT OF INSURANCE: I authorize any insurance benefits to be paid directly to the physicians providing services to the patient, all benefits due, and payable as a result of services rendered.

FINANCIAL RESPONSIBILITY: I understand that the physician will file claims with all insurance carriers as a courtesy. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer unless there is a specific written agreement between the physician, the patient and the payer.

MEDICARE PATIENTS: Medicare will pay only for services it determines to be "reasonable and necessary". If services that the physician has requested are denied for payment by Medicare, I agree to be personally and fully responsible for those charges.

ADVANCED DIRECTIVE: Do you have an Advanced Directive? ☐Yes ☐No
Would you like information regarding Advanced Directives? ☐Yes ☐No

ACKNOWLEDGMENTS

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how the patient's medical information will be used and disclosed by NRHS is in the "Notice of Privacy Practices". A copy has been provided to me in my registration packet and is posted in the clinical site. I have received and accepted a copy of NRHS "Notice of Privacy Practices". ☐Yes ☐No

Reason for refusal if "NO"____

PATIENT RIGHTS: I have received a copy of "Your Medical Treatment Rights Under Oklahoma Law" and "General Information Concerning your Rights & Responsibilities". ☐Yes ☐No

TELEPHONE CONSUMER PROTECTION ACT (TCPA): You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I have read this disclosure and agree that I may be contacted as described above.

____ ___________________
Signature Date

CERTIFICATION: I hereby certify that I have read each of the above statements, that they are true and correct to the best of my knowledge and I have had each item explained to me to my satisfaction. I further certify that I am the patient or duly authorized by the patient to accept the sign the agreement and accept its terms. A photocopy has the same effect as the original.

____ ________________ ____________________
Signature of patient/Guarantor/Authorized Person Relationship Date Signed

Norman Regional Health System

Norman Regional Hospital	901 N. Porter Ave., Norman, OK	405.307.1000
Norman Regional Moore	700 S. Telephone Rd., Moore, OK	405.793.9355
Norman Regional HealthPlex	3300 HealthPlex Parkway, Norman, OK	405.515.1000

General Information Concerning Your Rights & Responsibilities

We acknowledge your fundamental right to considerate care that safeguards your personal dignity and to information that helps us meet your care needs and preferences.

As a patient you have a right to:

Communication

Receive information in a manner you understand, tailored to your age, language, and ability to understand.

Receive language interpretation services as needed at no charge.

Communication that addresses any vision, speech, hearing or cognitive impairments and provides information in a manner that meets your needs at no charge.

Receive a copy of Norman Regional Health System's Notice of Privacy Practices and the patient rights included in that document.

Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and healthcare providers who will see you.

Access information contained in your medical record within a reasonable time frame-usually within 48 hours of request.

Know which Health System rules and policies apply to your conduct while a patient.

Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.

Have a family member, friend or other individual to be present for emotional support during the course of your stay; unless the individual's presence infringes on others' rights, safety or is medically or therapeutically contraindicated. The individual may or may not be your surrogate decision-maker or legally authorized representative.

Have a family member or representative of your choice notified promptly of your admission to the Health System.

Have your personal physician notified promptly of your admission to the Health System.

Be advised of the Health System grievance process, should you wish to communicate a concern regarding the quality of the care you receive or if you feel determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that you will be provided with a written notice of the grievance determination that contains the name of the hospital contact person, the steps taken on your behalf to investigate the grievance, the results of the grievance and the grievance completion date.

Please contact the Patient Liaison for your care related issues or to report a grievance. The Patient Liaison can be contacted at 405-307-1060. You may also report a grievance to the Oklahoma State Department of Health at:

Medical Facilities Services - Complaints
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone: 405-271-6576 or 800-234-7258
medicalfacilities@health.ok.gov

Informed Consent

We encourage a partnership between you as a patient and your healthcare team.

As a partner in your care, you have a right to:

Become informed of your rights as a patient in advance of, or when discontinuing, the provision of care. You may appoint a representative to receive this information should you so desire.

Receive information from your physician about your illness, course of treatment, outcomes of care (including unanticipated outcomes), and your prospects for recovery in terms that you can understand.

Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

Exercise these rights without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression or the source of payment for care.

Be advised if Health System/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

Safety

Norman Regional Health System is committed to ensuring that your care is provided in the safest manner possible by incorporating patient safety into our culture, making it a top priority for all employees, medical staff, volunteers, students and contracted personnel.

You have a right to:

Expect that the Health System staff will check your armband before you receive any medication, treatment, test or procedure.

Considerate and respectful care, provided in a safe environment, free from all forms of abuse or harassment.

Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

Know that all environmental safety issues are addressed in an appropriate and timely manner. Any patient safety issues can be addressed to the Health System by contacting the Patient Safety Hotline (405-307-7899).

Norman Regional Health System is committed to reducing health care errors in our organization. If you have concerns about safety at our facilities, you are encouraged to call us to share your concerns by calling the Patient Safety Hotline at 405-307-7899 or by speaking with our Patient Liaison at 405-307-1060.

If concerns are regarding patient privacy, call the Privacy Officer at 405-307-1405 or contact the Compliance Hotline at 1-877-267-1929.

If concerns in question cannot be resolved at this level, you are encouraged to contact the Joint commission at:

One Renaissance Blvd
Oakbrook Terrace, IL 60181
Fax #: 630-792-5636
Email: complaint@jointcommission.org

or

Oklahoma State Department of Health
Medical Facilities Service-Complaints
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone: 405-271-6576
Email: medicalfacilities@health.ok.gov

For concerns regarding discrimination based on race, color, national origin, disability, age, sex, sexual orientation, gender identity, religion, creed, blind or other sensory disabilities consistent with applicable state and federal law, please contace the ADA Section 504 Coordinator at 405-307-1405.

US Department of Health and Human Services Office of Civil Rights
1301 Young Street, Ste 1169
Dallas, TX 75202
www.hhs.gov/ocr

Pain Management

Norman Regional Health System has an ongoing Pain Management Initiative and Education program in place that focuses on effective pain management for patients.

As a patient you have a right to have your pain and "reports of pain" to be:

Effectively managed while a patient at Norman Regional Health System.

Taken seriously and promptly treated.

Treated with dignity and respect by doctors, nurses, pharmacists and other health care professionals.

Reassessed regularly with pain medication adjusted if your pain has not been eased.

Informed of possible treatments, benefits, risks and cost managing your pain.

Treatment Options

Your healthcare team will describe your proposed treatment to you.

As a partner in the treatment plan, you have a right to:

Participate in the development and implementation of your plan of care and actively participate in decisions regarding that care. To the extent permitted by law, this includes the right to request and/or refuse treatment.

Request consultation with the Health System's Ethics Committee concerning ethical implications of your care.

Reasonable continuity of care should you need a service not provided by Norman Regional Health System you have the right to be assisted in transferring to another healthcare facility that can provide the needed service.

Leave the Health System even against the advice of your physician.

Be informed by your physician or a delegate of your physician of the continuing healthcare requirements following your discharge from the hospital.

End-Of-Life Decisions

In order to make appropriate decisions, patients nearing the end of life and their families need to know and understand their choices. As a start in making those decisions an informational brochure is available. You have the right as a patient to ask questions about treatment choices. Norman Regional Health System's medical staff, chaplains, case managers, nurses and other healthcare professionals are close by to help explain the choices available in making end-of-life decisions.

As a patient you have a right to:

Complete Advance Directives regarding your healthcare (including Living Will, Health Care Proxy, Durable Power of Attorney for Health Care, and/or Do Not Resuscitate Consent documents) and have Health System staff and practitioners who provide care in the Health System comply with these directives to the extent provided by state laws and regulations.

Complete Do Not Resuscitate Directive regarding your healthcare, and have Health System staff and practitioners who provide care in the Health System comply with these directives to the extent provided by state laws and regulations.

These documents allow you to give directions about your future medical care or to legally designate another person or persons to make medical decisions for you if you are temporarily or permanently incapable of doing so.

Confidentiality

The staff of Norman Regional Health System strives to respect your privacy and confidentiality at all times and under all circumstances. Access to your information confers an obligation on us to protect your privacy and personal interests.

As a patient you have the right to:

Full consideration of privacy concerning your medical care program and your personal health or individual health information. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual involved in your healthcare.

Confidential treatment of all communications and records pertaining to your care and stay in the hospital. Your written permission will be obtained before your medical records can be made available to anyone not directly concerned with your care.

Financial

As a patient you have a right to:

Examine and receive an explanation of your bill regardless of source of payment.

Your Responsibilities as a Patient at Norman Regional Health System

The care you receive depends partially on you. Therefore, in addition to these rights, you and at times your family and/or support person have certain responsibilities as well. These responsibilities are presented to you in the spirit of mutual trust and respect. **Together as partners in your health, it is our Code of Mutual Trust.**

You as a patient at Norman Regional Health System have the following responsibilities to:

Provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.

Report perceived risks in your care and unexpected changes in condition to the responsible practitioner.

Ask questions when you do not understand explanations about your care or what you are expected to do.

Follow the treatment plan established by your physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.

Keep appointments and to notify the hospital or physician when you are unable to do so.

Know that you are responsible for your actions should you refuse treatment or not follow your physician's orders.

Assure that the financial obligations of your hospital care are fulfilled as promptly as possible.

Follow Health System policies and procedures.

Be considerate of the rights of other patients and Health System personnel.

Be respectful of your personal property and that of other persons in the hospital.