

Westview Health Clinic
3140 W Hayes
Clinton OK 73601
Telephone: 580-323-1937 Fax: 580-323-1156

Patient Authorization Form

Patient Name: _____
Reason for Visit: _____ Primary Care Provider: _____
Mailing Address: _____ City: _____ ZIP: _____
Street Address (if different than mailing): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Message: Yes _____ No _____ Message: Yes _____ No _____ Message: Yes _____ No _____

Date of Birth: _____ Social Security Number: _____
Marital Status: _____ Email Address: _____
Message: Yes _____ No _____

Emergency Contact Name: _____ Phone Number: _____
Relationship: _____ Address: _____

Pharmacy Name: _____ Pharmacy Number: _____

Is this visit related to Workers Comp? _____ Or any other type of accident? _____

Employer Name: _____ Phone Number: _____
Address: _____

Copy of Insurance Cards will be kept in Patient Files

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Kristy R. Baker ARNP/ Westview Health Clinic for all my insurance or cash claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles, non-covered services, and cash pay amounts are due at the time of service.

Signature of Responsible Party: _____

Date: _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____

Acknowledgment of Receipt of this Notice

Westview Health Clinic is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Westview Health Clinic

Name of Patient (PRINT) _____

Signature of Patient or Authorized Representative

Date

In accordance with the HIPPA guidelines this practice is authorized to discuss my medical information with the following individuals.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Consent for Examination

I will be seen by a Nurse Practitioner who has acquired advanced education, special knowledge, and skills in the evaluation, diagnosis, treatment, education, risk assessment, health promotion, case management, coordination of care, and counseling in the primary care of adults.

___ I, _____, hereby request that the Nurse Practitioner examine and treat me.

___ I, _____, hereby request that the Nurse Practitioner examine and treat the dependent in my care, _____.

Signature _____

Date _____

Receptionist _____

Date _____

Westview Health Clinic

Quick Clinic History Form

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name:		First:		Age:		Sex:	
Why are we seeing you today:							
ILLNESS/INJURY: Please check if you have ever had:							
Yes	No		Yes	No			
		High blood pressure				Kidney Stones	
		Diabetes				Abdominal bleeding	
		Peptic ulcers				Diverticulosis	
		Heart attack				Thyroid problem	
		Chest pain/tightness				Lung problems/asthma	
		History of heart murmur				Shortness of breath	
		Stroke				Accidents/broken bones (list)	
		Cancer					
		Hepatitis					
		Gallstones					
OPERATIONS: List names and dates of all operations you have had <input type="checkbox"/> None							
Year	Name of Operation		Type of Anesthetic, if Known		Complications		
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____							
List any hospital admissions or medical conditions not list above: _____							
FEMALES ONLY Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No							
DRUGS: Please list all drugs you take and their dosages. <input type="checkbox"/> None							
Drug	Dosage	Drug	Dosage				
ALLERGIES: Please list type and reaction <input type="checkbox"/> None							
Name of Drug	Reaction		Name of Drug	Reaction			
Do you now use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Pack /Day ___ / ___ # Years ___							
Have you ever used tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Yrs Quit _____							
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____							
Have you ever used alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No							
The above information is true and accurate.							
Patient Signature (parent if patient is a minor) _____						Date _____	