Welcome to The Doctor's Office: Oakes Family Care

New Patient Consent Form

Please complete the following form. This will become part of your office record and will be held in strict confidence.

Date _____

Information on Patient

Name (Mr / Miss / Ms / Mrs / Dr)

_____

Last name First name MI

Nickname _____ Email Address _____

Sex (Check One): ☐ Male ☐ Female

Home Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Cell Phone _____ Contact Preference ☐ Home ☐ Work ☐ Cell

Date of Birth _____ SS # _____

Ethnicity ☐ Caucasian ☐ African-American ☐ Asian
☐ Hispanic ☐ American Indian ☐ Other _____

Marital Status ☐ Single ☐ Married (How Long? _____)
☐ Separated ☐ Divorced (How Long? _____) ☐ Widowed

In Your Household, You Are: ☐ Head of Household/Spouse ☐ Child ☐ Niece/Nephew
☐ Grandparent ☐ Grandchild ☐ Unrelated
☐ Other_____

Number of People Living in Your Household_____

Occupation _____

Education: Highest Grade or Level Completed_____

Physician _____

Referred by _____ Relationship to Referring Person _____

Information on Party Responsible for Payment

☐ Check here if this information is the same as in the box above.

Home Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Date of Birth _____ SS # _____

Employer _____

Relationship to Patient_____

I agree to be responsible for any charges for services and materials supplied by **The Doctor's Office: Oakes Family Care** and its doctors for the above patient.

_____

Signature of Party Responsible for Payment Date

The Doctor's Office: Oakes Family Care

Notice of Personal Belongings

Policy The Doctor's Office: Oakes Family Care is not responsible for any personal belongings of patients and visitors.

Valuables Any excess money or other valuables should be turned over to family or friends and removed from the clinic's premises.

_____

Patient's Name or Signature Date

_____

Patient's Parent, Guardian, or Representative Signature Date

Note: If the patient is an adult and competent, he or she should sign and date personally on the first line. If he or she is a minor, incompetent, or unable to sign, the patient's parent, guardian or representative should sign and date on the second line.

The Doctor's Office: Oakes Family Care

Agreement on the Use of Electronic Messaging for Patient Communications

Agreement on the Use of Electronic Messenging for Patient Communications between Luther Brandon Oakes, MD, his staff and _____ (Print Patient's Name).

I. Use of Electronic Communications. I agree and understand that I may use electronic methods to communicate with my Physician regarding my care and treatment, and with The Doctor's Office: Oakes Family Care staff regarding certain administrative matters arising from health care services rendered to me. I will not use electronic communications with my Physician and his staff and will use other means of communication (e.g., telephone, personal visit) for:

(a) emergencies or other time-sensitive issues;

(b) inquiries which deal with sensitive information; and

(c) situations in which a response is delayed.

My Physician and his staff will make a reasonable attempt to return all electronic messages received within five business days. However, if I do not receive a response by the close of business on the fifth business day following my message, I agree to use other means of communication to contact my Physician. Similarly, I agree that my Physician may use his/her reasonable professional judgment to determine whether any response electronically is appropriate or practical, and request that I either speak with my Physician and/or his staff by telephone or make an appointment for an in-person visit.

II. Composing Electronic Messages. When composing electronic messages to my Physician and his staff, I will:

(a) write concisely;

(b) include my full name and a brief description of the nature of the request (e.g., "prescription refill", "medical advice", "billing question");

(c) keep copies of electronic messages sent and received;

(d) when requested by my Physician or his staff, send a reply to acknowledge receipt and review of the electronic message from my Physician or his staff.

III. Access to Patient's Electronic Communications. By entering into this agreement, I understand and acknowledge that it may be necessary for The Doctor's Office: Oakes Family Care staff, other than to whom the message is addressed to access electronic messages sent by me to my Physician, in order to help my Physician organize and respond to electronic messages received from me, to cover for my Physician if he is not available, and, in some cases, to assist in generating a response. I hereby authorize any staff member of The Doctor's Office: Oakes Family Care to access my electronic messages. Further, my Physician may use non-clinical personnel to organize and respond to electronic messages regarding billing or other administrative matters. I hereby authorize non-clinical personnel of The Doctor's Office: Oakes Family Care to access electronic messages sent to my Physician which includes inquiries related to administrative matters.

IV. No Liability. I agree that electronic communication with my Physician and his staff is offered as a convenience to me, and I will not hold my Physician and his staff responsible for any expense, loss or damage caused by, or resulting from: (i) a delay in my Physician's response to me, or any damage to me resulting from such delay, due to technical failures, including, but not limited to, technical failures attributable to my Physician's Internet service provider, power outages, failure of The Doctor's Office: Oakes Family Care 's electronic messaging software, failure by my Physician or me to properly address electronic messages, failure of The Doctor's Office: Oakes Family Care's computers or computer

network, or faulty telephone or cable data transmission; (ii) any interception of electronic communications between me and my Physician and/or his staff by a third party; or (iii) my failure to comply with the guidelines regarding use of electronic communications set forth in Section 1, above.

V. Confidentiality. My Physician and his staff will ensure the confidentiality of my electronic communications; however, I understand that electronic communications to my Physician and his staff are not secure, and there is therefore some possibility that the confidentiality of such communications will be breached by a third party. I am also aware that the confidentiality of my electronic communications with my Physician and his staff may be breached if I use an employer-provider computer for such communications, as an employer has the right to review any electronic communications transmitted through the employer's Internet system. Communication regarding highly confidential medical matters should therefore be reserved for other forms of communication (e.g., telephone, personal visit).

VI. Archiving. The Doctor's Office: Oakes Family Care may keep copies of electronic messages that I send to my Physician and his staff, and may include such messages in my medical record.

VII. Termination. This agreement may be terminated by my Physician and his staff if he determines that I have failed to comply with the provisions specified in this agreement. Upon termination of this agreement, my Physician and his staff will no longer respond to my electronic communications in the regular course of providing services. However, my Physician and his staff will reserve the right to respond to any electronic communications from me, if my Physician determines that such a response is appropriate or practical.

VIII. Miscellaneous. This agreement will constitute the entire understanding between the parties with respect to electronic communications, and will supersede any prior understanding or agreement between the parties, whether oral or written.

Organization: The Doctor's Office: Oakes Family Care

Patient Name: _____

Patient Signature: _____

Physician Signature: 

The Doctor's Office: Oakes Family Care

Personal Representative Designation

The purpose of this form is to designate a patient's Personal Representative(s) for discussion and disclosure of Personal Health Information. The designation is voluntary and in no way affects benefits, claims processing and payment, or eligibility status.

Patient Information

Patient Name:	Date of Birth:	Policy #:

Type of Information

The Doctor's Office: Oakes Family Care may discuss or release Personal Health Information to the Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through **The Doctor's Office: Oakes Family Care**.

Authorized Use and/or Disclosure

I authorize **The Doctor's Office: Oakes Family Care** to release Personal Health Information to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider or other person subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. **The Doctor's Office: Oakes Family Care** is not responsible should my Personal Representative further disclose my protected Personal Health Information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating a "no limitation" on disclosure of Personal Health Information.

Disclosure Limitations:

_____

_____

Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan Administrator. Revocation will not affect any action that **The Doctor's Office: Oakes Family Care** has taken or any information that has already been released based upon prior authorizations.

Designation of Personal Representatives(s)

Name of Authorized Person:	Relationship to Patient:	SS#:
Name of Authorized Person:	Relationship to Patient:	SS#:
Name of Authorized Person:	Relationship to Patient:	SS#:

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned patient or an authorized legal representative of the above-mentioned patient. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

_____

Signature of Patient/Legal Representative Date

_____

Printed Name of Legal Representative Description of Legal Representative Relationship to Patient

The Doctor's Office: Oakes Family Care
Patient History

Name _____

Ethnic Group:
□ Caucasian □ African-American □ Asian
□ Hispanic □ American Indian □ Other _____
Marital Status:
□ Single □ Married (How Long? _____)
□ Separated □ Divorced (How Long? _____) □ Widowed
Children:
Girls _____ Boys _____

Water Source at Your Residence (Circle One): Well Water City Water

Reason for your consult at The Doctor's Office: Oakes Family Care?
_____
When did you last feel well (absent of all symptoms)?
_____
Describe the two primary reasons that you are here today:

	Reason 1	**Reason 2**
Explanation		
Date symptoms first occurred		
Frequency of symptoms		
What makes conditions improve?		
What makes conditions worse?		
Do you think this problem will resolve itself?	**□ Yes □ No**	**□ Yes □ No**
Previous treatment		
Practitioner who provided treatment	**Name:** **Phone:**	**Name:** **Phone:**

Who suggested that you seek consult at **The Doctor's Office: Oakes Family Care**?
□ Self □ Referring Medical Professional □ Family
□ Neighbor/Friend □ The Court

History:

Significant Birth Events:

Premature birth? □ Yes □ No

If yes, how many premature?_____

List all childhood illnesses (continue on reverse if necessary):

Illness *Date(s)*

_____

_____

_____

List all surgeries (continue on reverse if necessary):

Procedure *Date(s)*

_____

_____

_____

_____

_____

_____

List all injuries (continue on reverse if necessary):

Injuries *Date(s)*

_____

_____

_____

Have you been diagnosed with any of the following (currently or in the past)?

__ Heart Attack	__ Kidney Problems	__ Stroke
__ CHF	__ Thyroid Problems	__ Arthritis
__ Seizure Disorder	__ Glaucoma	__ Diabetes
__ High Blood Pressure	__ High Cholesterol	__ Ulcers
__ Obesity	__ Oral Gum/Bone Problem	__ Cancer
__ Periodontal Disease	__ Liver Disease	__ Cataracts
__ Depression	__ Manic-Depressive Disorder	__ Other (List Below)

_____

List any other medical conditions you have had (do not include common cold or flu):

Illnesses *Date(s)*

_____

_____

_____

How often do you get a cold? _____

If your family has a history of any of these conditions, please do the following:

a. Circle the condition

b. Write 'F' for father, 'M' for mother, or 'S' for sibling within the parentheses

( ) Heart Attack	( ) Kidney Problems	( ) Stroke
( ) CHF	( ) High Blood Pressure	( ) Diabetes
( ) Cancer	( ) Depression	( ) Schizophrenia
( ) Obesity	( ) Manic-Depressive Disorder	( ) Other (List Below)
( ) Seizure Disorder	( ) Alcoholism	_____

List known allergies (including medication allergies): □ No known allergies

_____

List all prescription and over-the-counter medications you are currently taking. For prescriptions, note the name of the prescribing Physician (continue on reverse if necessary):

Prescription Medication *Dosage* *Prescribing Physician*

List all prescription and over-the-counter medications you have recently taken, but have since discontinued. Please note length of use (continue on reverse if necessary):

Prescription Medication *Dosage* *Date(s)*

List all supplements/alternative remedies (vitamins, minerals, herbs, etc.) you are currently taking and/or alternative treatments you are undergoing (continue on reverse if necessary):

Supplement/Alternative Treatment *Size (mg, mcg, etc.)* *Daily Dose*

Are your immunizations up to date? Yes No Unsure

List any handicaps or impairments (such as vision or hearing loss):

List travel from the past two years (continue on reverse if necessary):

Destination *Date(s)*