Invictus Healthcare System

9709 E 79th St Tulsa, OK 74133
Phone: 918-994-4000
Fax: 918-994-4090

New Patient Forms

Patient Information

Legal Name (Last / First / Middle)			Preferred Name
Social Security Number	Birth Date	☐ Male ☐ Female	Marital Status ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed
Street Address	Zip	City	State
Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Preferred Contact Method ☐ Text ☐ Phone ☐ Email ☐ Other	
Email **Required*	Occupation	Employer Name & Phone Number	
Primary Care Provider	Referring Provider		

As part of the American Recovery and Reinvestment Act, healthcare providers are required to obtain the following information. Please check the boxes in section 1-3 that most apply to you.

1. Race (Choose One)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White / Caucasian

2. Ethnicity (Choose One)

☐ Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Declined to Specify

3. Preferred Language (Choose One)

☐ Arabic ☐ English ☐ Hebrew ☐ Korean ☐ Spanish/Castilian ☐ Urdu
☐ Bulgarian ☐ French ☐ Hindi ☐ Polish ☐ Somali ☐ Vietnamese
☐ Chinese ☐ German ☐ Italian ☐ Portuguese ☐ Swahili ☐ Declined to Specify
☐ Central Khmer ☐ Haitian ☐ Japanese ☐ Russian ☐ Thai

Responsible Party (Policy Holder) / Legal Guardian *If minor, please have parent or legal guardian complete the following.*

☐ Self

Legal Name (Last / First / Middle)	Relationship to Patient ☐ Parent ☐ Other ☐ Spouse	Birth Date
Social Security Number	Address	☐ Check here if same address as above
Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

Emergency Contact

Name (Last / First / Middle)		Relationship to Patient
Address		
Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

Insurance

Primary Insurance Name and ID#:	Secondary Insurance Name and ID#:
Policy Holder Name and DOB:	Policy Holder Name and DOB:

Patient Name: _____ DOB: _____

MEDICATION AGREEMENT

Invictus Healthcare System understands that you may be experiencing pain. However, in order to control your pain after a major operation, we do retain the right NOT to fill any prescription for any narcotic before your surgery.

Refill requests:

- To avoid delays, please initiate refill requests 3 business days prior to being out of medication. Do NOT wait until you are out of medication.
- To initiate a refill request, please contact your pharmacy and provide them with the prescription number listed on the bottle of your last prescription.
- PLEASE ALLOW OUR OFFICE 24 HOURS TO PROCESS/RESPOND TO PRESCRIPTION REQUESTS.
- Medication refills are only addressed during office business hours, Mon-Thur 8am-5pm and Fri 8am-12pm.
- To follow up on refill requests, please contact your pharmacy first. If your insurance requires a prior authorization or there is an issue the pharmacy can not address, please contact our office at that time.

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

Many of our patients allow family members such as their spouse, parent, adult children or others to call and request medical, scheduling, and/or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to allow your medical, scheduling, and/or billing information to be released to family members, you must sign this form.

Signing this form will only give information to the individual(s) indicated below. I understand that I may cancel this consent at any time (in writing to Invictus Healthcare System), but that canceling it will not affect any information that has already been released. I understand that information disclosed to any recipients listed below is no longer protected by federal or state law and may be subject to disclosure by the recipient. I authorize Invictus Healthcare System to release my medical, scheduling, and/or billing information to the following:

Name _____ Relation _____ Phone Number _____

Name _____ Relation _____ Phone Number _____

FINANCIAL POLICY & AUTHORIZATION FOR TREATMENT

Invictus Healthcare is committed to providing high quality healthcare services to all of our patients in an ethical and cost effective manner. To achieve this goal, we need your assistance by understanding and following our financial policy. Signing this form indicates you understand the financial payment policy of this practice is to collect for services in full at the time of the patient's visit and the following:

- We accept cash, check, money orders, Visa and MasterCard.
- Co-payment, deductibles and coinsurance are due in full at the time of service.
- Please provide correct billing information or any other change of information when checking in for each visit.
- All services that require pre-authorization must be authorized prior to service being rendered.
- $50 no-show fee is applied for office visits and $75 no-show fee is applied for procedural visits that are canceled or rescheduled within 24 hours of the appointment time.
- $25 form completion fee is required in advance (example: FMLA, Disability, Etc).
- Patients and Guarantors are responsible for all charges resulting from treatment provided by Invictus Healthcare.
- Indian Health patients are responsible for bringing x-ray and referral to each appointment.
- In regard to Workers' Compensation, we only accept Oklahoma Workers' Compensation.
- Returned checks will be charged to the patient's account with a service fee of $25. Returned checks not redeemed within 10 working days of written notice to the maker may be referred to the prosecutor for collection.
- Unpaid delinquent accounts will be assigned a collection agency or attorney for collection and reported to the credit bureau.

DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice and feel free to ask any questions you may have about the following information. As a patient of Invictus Healthcare System, you may be referred to Oklahoma Surgical Hospital (OSH) for surgical, imaging and/or or other tests/procedures that your condition may warrant. **OSH is a physician-owned hospital in which, Dr. Gregory Wilson, holds a minority ownership interest.**

This hospital was founded in 2001 by local physicians who were determined to provide their patients with outstanding medical care in a quality environment that offered superior personalized service. Today their goal remains to provide their patients with a hospital option that allows physicians to be involved in all aspects of their healthcare delivery to ensure the focus stays on quality patient care.

Please note that you have the right to choose the provider of your health care services. Therefore, you have the option to use a health facility other than Oklahoma Surgical Hospital if you choose. You will not be treated differently if you choose to obtain health care services at a facility other than Oklahoma Surgical Hospital. If you have any questions concerning this notice or anything in it, please feel free to ask your physician or any representative here. In addition, if you would like additional information about Oklahoma Surgical Hospital's and its clinical and emergent capabilities please contact Valerie Ballenger, R.N., Chief Nursing Officer at 918-477-5091 or Rick Ferguson, Chief Executive Officer at 918-271-2756.

_____ _____ _____

Date Printed Name Signature

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Patient _____ DOB_____

Coordination of Care

Referring Provider's Name	Primary Care Physician's Name	Cardiologist's Name	Neurologist's Name
Nephrologist's Name	Urologist's Name	Oncologist's Name	Other

Medications *Include over-the-counter medications and supplements.* ☐ *Check box if NO medications.*

Drug Name	Dosage Strength (i.e., mg/mcg)	How many times a day?
1		
2		
3		
4		
5		
6		
7		
8		

Attach additional list if there are more medications

Allergies ☐ *Check box if there are NO medication allergies.*

Drug Name / Drug Class / Food	Reaction
1	
2	
3	
4	

Preferred Local Pharmacy

Name _____ Location _____

Phone _____ Fax _____

Medical History *Check all that apply. Describe details of medical conditions in spaces below.*

- ☐ Blood clots
- ☐ Cancer: Type _____
- ☐ Celiac Disease
- ☐ COPD (Emphysema)
- ☐ Crohn's Disease
- ☐ Cushing's Disease
- ☐ Depression
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Gastric Bypass
- ☐ Heart Disease:Type _____
- ☐ Heart Failure
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Jaw Pain
- ☐ Kidney Disease: Type
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Leukemia/Lymphoma
- ☐ Liver Disease: Type
- ☐ Lupus
- ☐ MI (Heart Attack)
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Problems With Vision
- ☐ Vitamin D Deficiency
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thalassemia/Sickle cell
- ☐ Ulcerative Colitis
- ☐ Enlarged Prostate

☐ Other:

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Surgeries *Check all that apply. Describe details of surgery in spaces below.*

☐ Angioplasty	☐ Cataract: ☐ Left ☐ Right	☐ Knee Replacement: ☐ Left ☐ Right
☐ Appendectomy	☐ Colon Surgery: Type _____	☐ LASIK
☐ Athroscopy Knee: ☐ Left ☐ Right	☐ C-Section	☐ Liver Biopsy
☐ Back Surgery: Type _____	☐ D&C	☐ Mastectomy: ☐ Left ☐ Right
☐ Breast Biopsy: ☐ Left ☐ Right	☐ Gallbladder	☐ Ovary Removed: ☐ Left ☐ Right
☐ Breast Implants	☐ Gastric Bypass	☐ Prostate Surgery: Type_____
☐ Breast Reduction	☐ Groin Hernia Repair: ☐ Left ☐ Right	☐ Thyroid Surgery
☐ CABG (Heart Vessel Bypass)	☐ Hip Fracture Repair: ☐ Left ☐ Right	☐ Tonsillectomy
☐ Cardiac Pacemaker	☐ Hip Replacement: ☐ Left ☐ Right	☐ Tubes Tied
☐ Carpal Tunnel: ☐ Left ☐ Right	☐ Hysterectomy	☐ Vasectomy

**Items in gray are for females only*

☐ Other:

Do you have any implantable devices? ☐ Pacemaker ☐ Defibrillator ☐ Stimulator of any kind ☐ Stent ☐ Other:_____

Family History ☐ Adopted - unknown

☐ ADD/ADHD	☐ Alcoholism	☐ Allergies	☐ Alzheimer's	☐ Asthma
☐ Cancer: Type: _____		☐ Depression	☐ Diabetes ☐ 1 ☐ 2	☐ Migraines
☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Mental Illness	☐ Bleeding Disorder
☐ Osteoporosis	☐ Seizure	☐ Stroke	☐ Thyroid Disease	☐ tuberculosis
☐ Ulcerative Colitis	☐ Other:_____			

Preventive Screenings *list dates of the most recent preventive services you've received.*

Test	Test Never Performed	Performed Where?	Last Exam Date	Findings/Results
Colonoscopy	☐	_____	_____	_____
Bone Density	☐	_____	_____	_____
Blood Sugar	☐	_____	_____	_____

Women's Health History ☐ N/A

Date of last mammogram? _____ Result? _____ ☐ N/A

☐ Pre-menopausal ☐ Currently Menopausal ☐ Post-menopausal ☐ N/A

If you have achieved menopause, what age? _____ What Year? _____
☐ Natrual ☐ Surgical *(Choose one)*

Social History *your answers help determine your risk for certain diseases. Responses are confidential.*

Tobacco Use ☐ Yes ☐ No

Do you... ☐ smoke a pipe ☐ smoke cigarettes
☐ chew tobacco ☐ Other: _____

How many... packs per day? _____
years? _____
If you quit, what year?

Do you drink *alcohol?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *illegal drugs?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *caffeine?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

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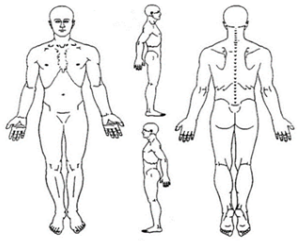
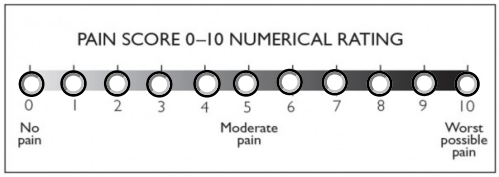
Today's Visit *Your answers help determine applicable treatment options.*

How did you hear about our office?

Indicate on the diagram below the area(s) bothering you.
Use "X" for pain and "O" for numbness.



Click your current level of pain on the diagram below.



Is today's visit related to a Motor Vehicle Accident(MVA) claim or a Workers' Compensation(WC) claim?
☐ Yes, MVA ☐ Yes, WC ☐ No
If yes, is this an open/active claim?

Briefly describe your reason for seeing the provider today.

If applicable, how did the injury occur?

What words best describe your pain? (check as many that apply)
☐ Sharp ☐ Burning ☐ Throbbing ☐ Shooting ☐ Aching
☐ Cramping ☐ Stabbing ☐ Crushing ☐ Electricity ☐ Tingling
☐ Coldness ☐ Hotness ☐ Dull ☐ No pain ☐ Other:_____

Activities affected by pain/injury? (check as many that apply)

☐ Walking	☐ Bending	☐ Raking Leaves	☐ Combing hair
☐ Sitting	☐ Lying in bed	☐ Gardening	☐ Lawn mowing
☐ Climbing	☐ Stairs	☐ Using computer	☐ Running
☐ Chewing	☐ Exercising	☐ Shaving	☐ Washing dishes
☐ Cooking	☐ Sitting in recliner	☐ In/out bathtub	☐ Using Telephone
☐ Kneeling	☐ Doing laundry	☐ In/out of vehicle	☐ Brushing Teeth
☐ Sleeping	☐ Making the bed	☐ Driving	☐ Sexual Intercourse
☐ Standing	☐ Vacuuming	☐ Riding (passenger)	☐ Caring for pets
☐ Lifting Children	☐ Ironing	☐ Grocery Shopping	☐ Playing Piano
☐ Reading	☐ Swimming	☐ Carrying groceries	☐ Other:_____

What helps/eases the pain? (check as many that apply)
☐ Lying down ☐ Standing ☐ Exercise ☐ Medication ☐ Sitting
☐ Nothing ☐ No pain ☐ Other:_____

Have you received any of the following treatments for the problem we are seeing you for today? (please check any that apply)
☐ Chiropractic Therapy ☐ Physical Therapy ☐ Biofeedback
☐ Injection Therapy ☐ Tens Unit ☐ Surgery
☐ None ☐ Other:_____

Have you had any diagnostic testing done? (please check any that apply)
☐ X-Rays ☐ CT Scan ☐ MRI ☐ EMG ☐ Other:_____

Have you had a previous injury to the part of your body we are seeing you for today?
☐ Yes ☐ No
If yes, please explain:

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Osteoporosis Screening *Your answers help determine your risk.*

Have you been diagnosed with Osteoporosis (weak or brittle bone)? If yes, do you take medication for Osteoporosis (Fosamax, Forteo, Prolia, Reclast, Evenity)?	☐ Yes ☐ No ☐ Yes ☐ No
Do you take Calcium and/or Vitamin D?	☐ Yes ☐ No
Have you broken a bone after the age of 40? If yes, please describe:_____	☐ Yes ☐ No
Do you have a family history of Osteoporosis?	☐ Yes ☐ No
Did either of your parents ever have a broken or fractured hip?	☐ Yes ☐ No
Have you ever taken daily steroid medications (Medrol, Prednisone) for longer than 3 months?	☐ Yes ☐ No
Do you fall frequently?	☐ Yes ☐ No
Do you smoke cigarettes?	☐ Yes ☐ No
Have you had a Bone Density (DXA) scan within the past 2 years? If yes, please note when: _____	☐ Yes ☐ No
If you are female, do you receive hormone therapy (i.e. estrogen)?	☐ Yes ☐ No

Today's Date: _____ Patient Signature: _____

Patient Name: _____ DOB: _____

AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

In order for Invictus Healthcare System to provide you with the best possible care, we may require copies of your medical records. For us to obtain this information, we will need your written permission. Please review the Authorization and Consent for Release of Medical Records below. Your signature on this form will allow us to obtain the necessary information.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

PATIENT SECTION TO COMPLETE		
_____	XXX-XX-_____	_____
Today's Date	Last 4 of SSN	Date of Birth
_____	_____	
Printed Patient Name	Patient Signature	

MEDICAL RECORDS USE ONLY DO NOT COMPLETE THIS SECTION	
Record Holder:	Record Holder's Fax Number
Requested Medical Records: ☐ All dictated reports ☐ All radiology reports ☐ All anesthesia reports ☐ All therapy records ☐ Other:_____	

Please Fax Records to 918-994-4090