## **Optimal Health Associates**

Patient Demographic Form Please print neatly and fill in all blanks

Patient's Legal Name:				
(first)	(r	niddle)	(last)	
Date of Birth:	Ag <u>e</u> :	Social Secur	ity No	
Circle One: Single Married	Divorced Separated	Other:		
Patient's Address: (street address)	12	ity)	(-Amari)	2 K
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Home Phone:	Work Phone:		Cell Phone:	****
Employer:		Email Address:		
Primary Care Physician:		Phone Number:		
Referring Physician:		Phone Number:		
Name of the Primary Insurance Con Name of person who carries insurance: Carriers DOB:		Rela	tionship to Patient:	
Secondary Insurance Company (if a				
Name of person who carries insuran				
Carriers DOB/	Carriers SSN;		Carriers Employer	•
Spouse's Name:				
Nearest relative not living with you:_		Relationship:_	PI	d:
If patient's a minor, please list both p	parents information:			
Mother:	Employer:_		Ph:	
Father:  I hereby authorize my insurance benefits	Employer:_		PH;	
I hereby authorize my insurance benefits covered services. I also authorize the ph and agree and received a copy of the HIP	ysician to release my inf	e facility and the phormation in the proc	ysician. I am financiall essing of any insuranc	y responsible for non- e claims. Tacknowledge
Signature			Date	

Print in Color or Grayscale	Only
Using Adobe Acrobat Reacter 8.0 or	

# Medications and Allergies Please answer every question.

[ [ ] [ ] [ ]	STAFF:	All Items on this
( )		page must be
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Noel R. Williams, M.D.
Benjamin J. Barenberg, M.D.
Abbey Ronck, PA-C
Christina Telcocci, PA-C
Shannan Carmouche, PA-C
Tricia Hall, PA-C
Amy Brooks, APRN
Bethany Cook, APRN

## Authorization to Release Information via Phone/Family/Friends

Print your name:		DOB:
work, test results, treatments, a below. I authorize the staff to I the below numbers:	appointments, prescriptions, etc	ns or staff of this office regarding my healthcare, lab to be received at any of the phone numbers listed with the individual who answers the phone at any of a NOT wish to be contacted
Home Phone:	Cell:	Other:
status of appointments, treatme	ent plan, medications, and/or acco at I have requested. (Leave blank	/or friend) to call the office on my behalf to verify the untinformation. These individuals may also pick up if you do not authorize any other individual to access
Name:	Relation:	Phone Nbr:
		Phone Nbr:
Name:	Relation:	Phone Nbr:
.Namë:	Relation:	Phone Ñbṛ:
Below is the pharmacy name an	d phone number that I will use for	all prescriptions
Pharmacy Name:		Pharmacy Number:
I understand this authorization	will remain in effect until I revoke	the authorization in writing.
Patient Signature	<u> </u>	Date

Noel R. Williams, M.D.
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#### **AUTHORIZATION FOR TREATMENT**

I hereby authorize the Physicians(s) in charge of the care of the patient to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIMS

I hereby authorize the physician(s) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of the physician's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, welfare funds, the Social Security Administration or it intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AT ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release TPG, it agents and employees from liability in connection with the release of information contained therein.

#### ASSIGNMENT OF INSURANCE BENEFITS

Thereby authorize payment directly to my physicians(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit. I understand I am financially responsible for charges not covered by this assignment.

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Print Patient Name		
	Date:	
Patient's Signature		
	Date:	
Or Responsible Party Signature (parent of minor, etc)	Date	
Or responsible Fairly signature (barein or minor, etc)		

Lunderstand a photocopy of this document is as valid as the original

## DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

- 1. Dr. Noel Williams and Dr. Benjamin Barenberg have an ownership interest in Community Hospital and Northwest Surgical Hospital.
- 2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.
- 3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitaloke.com or nwsurgicaloke.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and tinderstand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

Signature of Patient	Signature of Parent or Guardian (if applicable)
Print Name of Patient	Print Name of Parent or Guardian
Dated:	•



### **Attention Optimal Health Patients**

Optimal Health has established a protocol for directing patient lab orders based on the patient insurance.

Our usual protocol is to perform labs at the Broadway location using our IN-HOUSE lab for insurances that Optimal Health is contracted with; including Blue Cross Blue Shield.

Since LabCorp will become the preferred in-network provider for Blue Cross Blue Shield on January 1<sup>st</sup>, 2017, Optimal Health will refer other outside testing to LabCorp.

If you have a laboratory preference for blood work and other gynecological tests, please acknowledge it below. We recommend verifying with your insurance plan benefits about your preferred lab provider.

I understand that each insurance plan has its own criteria for medical coverage and that I will be responsible for payment if testing is not fully covered, i.e., Cigna HMO, Cigna Open Access and strict Vitamin D criteria.

It is the patient's responsibility to inform the phlebotomist each time blood is drawn if they have a preferred Lab.

Please circle the laboratory of choice		
NO PREFERENCE		
IN-HOUSE LAB or IN-HOUSE LAB / LABCORP		
LABCORP		
DLO QUEST		
Other:		
Please sign below that you have read, understood,	and agree to this policy.	
Print Name:		
Patient Signature:	Date:	

## Optimal Health Associates CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

The purpose of this agreement is to prevent misunde	erstandings about certain medicines the patient will be taking
	This is to help both the patient and their provider comply with
the law regarding controlled medications. Please re	ad this contract thoroughly, as It is a condition of your

The use of oploids, benzodiazepines and stimulants may cause addiction, and is only one part of a complete treatment plan.

I agree to the following:

- 1. Fam responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine not prescribed to me.
- 2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
- 3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
- 4. I will not increase my medicine until I speak with my doctor or nurse.

Print Patient Name: \_\_\_\_\_\_ DOB:

continued treatment. Your signature will be regulred.

- 5. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- 6. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
- 7. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- 8. I agree to come to the office for a pill count at any time if asked by my doctor.
- 9. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
- 10. Lagree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test, and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit, and again randomly through the course of my treatment.
- 11. Junderstand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
- 12. I have been informed by my physician about narcotic effects, including the normal physiological effect of tolerance (where I might need to take more medication to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
- 13. I understand that narcotics can adversely affect my judgement in making business decisions, and in operating equipment such as an automobile.
- 14. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
- 15. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence that I am improving, or if progress is not being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician.

16. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

#### Refills

- I understand that refills of narcotic medication will be given only during my regularly scheduled
  appointment, or once monthly by telephone if the current prescription has been correctly used. If the
  medication requires a written prescription, i must call 3 business days in advance. If the medication does
  not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax
  the request to the office.
- I understand that refills will be made only during regular office hours Monday through Thursday, 8:30AM 4:30PM. No refills will be available on nights, holidays or weekends. Advance notice of 3 days is required.
- I must keep track of my medications. No early or emergency refills may be made. Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before the new prescription will be written.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is

#### Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain narcotics form this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if narcotics have been obtained from another physician.

#### Prescriptions form Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle; even if there are no pills left. I am not to see or accept medications form other providers without my doctor's permission.

#### Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way, and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

r have talked about this agreement with my doctor and I understand the above rules.							
Patient's signature	Date						
Physician's signature							

♦ Direction of Feed ♦

Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

### Men's Preventive Health

Please answer every question

Handwritten items must be entered <u>MANUALLY</u>.

Do not fold this form.

**Marking Instructions** PLEASE PRINT PATIENT'S FIRST NAME PATIENT'S DATE OF BIRTH Please use a #2 pencil. Fill in the complete oval as shown... Month Have you ever had any of the listed colon cancer screenings? If yes, please list approximate date. do not yes. no If yes, date: know Colonoscopy Sigmoidoscopy Barium enema Stool hemoccult (test for blood in stool) Have you been immunized against the following? If yes, please list approximate date. do not If yes, date: yes no know Influenza / Flu (within the past year) Measles, Mumps & Rubella / MMR Pneumonia Shingles / Zostavax Tetanus / Diphtheria (within last 10 years) Chickenpox / Varicella do not If yes, date: yes no Have you had your cholesterol know checked in the last five years? Have you had the following? n/a If yes, date: yes no Prostate cancer screening (age 40+) Any problems with sexual activity? If yes, date: ves no n/a Do you perform monthly self-testicular exams?

Do not write, stamp, punch holes or affix a sticker in this area.

## Personal / Family History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

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TOBACCO USE				•		
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If you quit smoking, at wha	it age did you quit?	smoking at the age of 21, you would fill in the ovals like this:	10			? <b>? ?</b> ?
How many cigarettes do yo smoke (or did you previously sm	· · · · · · · · · · · · · · · · · · ·					
How many cigars or pipes of	lo you smoke per weeki		none () 3-5 ()		<1 (1) 6-9 (1)	1-2 () 10+ ()
How many cans of smokele do you use per week?	ess / chewing tobacco	e de la companya de l	none ()		2 🔾	1/2 ( ) 3+ ( )
Are you exposed to passive	(second hand) smoke?	· · · · · · · · · · · · · · · · · · ·	yes 😂		no 🗘	
ALCOHOL USE	Numbe	r of times: ne	ver 🚍	<u>1</u> <u></u>	2 🕾	
How often do you drink alc	ohol?	Per	45	5 つ week つ	6 C month C	7+ 0 year 0
(If you marked "never", please skip	a altead to Drug Use section)			•		
What type(s) of alcohol do	you drink?		beer 🧢	)	wine 😂	liguor 😂
How many drinks do you h	ave per occasion?		1-2	3-5	6-9 <	) <b>10+</b> C
How often do you have mo than five drinks per occasio		kational di kasiona j <del>amakka</del> kangan na manaka "hakaida ka		never 🔷 rarely 😂		occasionally (
DRUG USE	none 🔆 cu	rrent 🗢	previous 🥽	pre	fer to discuss w	vith physician 🗢
HIV HIGH RISK BEHAVIOR? (HIV Risk Factors: IV drug use, mor unprotected sexual contact, contact			yes ⟨○⟩ no ⟨○○	•	fer to discuss w	vith physician
HABITS	Type(s) of c	affeine:	_coffee 🤤	) 	tea 🗇	soft drinks
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PAST MEDICAL HISTORY

## Personal / Family History

Please answer every question

Please indicate if YOU have a history of the following:

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Do not fold this form.

Alcohol Abuse	🗇 Diabetes			< ∩ Me	ental Illnes	s		
Anemia	Growth / Development Disorder			○ Migraines				
	Heart Attack Heart Disease Heart Pain / Angina Hepatitis A Hepatitis B Hepatitis C High Blood Pressure High Cholesterol		Osteoporosis Prostate Cancer					
Anxiety Disorder								
Arthritis				Rectal Cancer				
⇒ Asthma			Reflux / GERD					
Autoimmune Problems			Seizures / Convulsions					
Birth Defect(s)			Severe Allergy					
⇒ Bladder Problems			Sexually Transmitted Disease (5) Skin Cancer Stroke / CVA of the Brain					
Bleeding Disease								
Blood Clots								
⇒ Blood Transfusion(s)		Hives  Kidney Disease		Suicide Attempt Thyroid Problems				
⇒ Bowel Disease								
> Breast Cancer	Liver Cancer			Ulcer Other Disease, Cancer, or Significant Medical Illness				
Cervical Cancer	iver Disease							
Colon Cancer	Lung Cancer							
	C Lung / Respir	atory Disea	ase	NONE of the Above				
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Mother, Grandmother, or Sister developed heart disease before the age of 65 Father, Grandfather, or Brother developed heart disease before the age of 55

Lung / Respiratory Disease

Seizures / Convulsions Severe Allergy

Stroke / CVA of the Brain Thyroid Problems Other Cancer

Migraines Osteoporosis Rectal Cancer

#### ♠ Direction of Feed ♠

### Surgeries

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form,

Marking Instruction	ns per					
Please use a # 2 pencil	PLEASE PRI	NT PATIENT'S FIRST NAME	PATIENT	S DATE OF BIRTH		
Fill in the complete oval as shown						
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I have had no Surgeries. (n	o need to complete qu	estionnaire)				
Anal Fissure Repair	C Low Back Disc Su			Deviated Nose Septum		
Appendectomy	Neck Disc Surger	•		Tubal Ligation		
Hemorrhoidectomy	Sinus Surgery	Vasec	tomy			
Prostate Surgery	TURP	Removal	,			
Gallbladder Surgery	🥽 Open	😂 Laparoscopio	•			
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Hysterectomy (due to cancer)	( Partial	Complete				
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Spinal Fusion		C Lower Back				
Spinal Decompression		C Lower Back	processings a second work and an inchession of the processing of the contract			
Dilation and Curettage (D&C)	Single Single	( Multiple				
Lung Surgery	C Left	○ Rìght	○ Both	ener van een koor verene een een een een verene verene verden. Verlage bijvoor van van een verden verden verde		
Kidney Removal	i grande de la región de la conferencia	Right	O Both	e e e conservar en la maria en maria en la companya de la companya en la companya en la companya en la company La companya en la co		
Cataract Surgery	( Left	O Right	( ) Both	en e		
Breast Cancer Lump Removal		ري Right	Both	troponis terring compositions and accommodification of the commodition of the commodities of the commodities of the commodities		
Mastectomy		Right	→ Both	. The state of the		
Breast Reconstruction	C Left	Right	Both	ter annual residuant contract of the second		
Breast Reduction	Left	Right	Both	. Construction of the Cons		
Ovary Removal	THE CHARLES AND LESS AND ADMINISTRATION OF THE PROPERTY OF THE	Right	Both	o sometima omit kunimadan ingentra menandiri mesawa menandiri belah salah menandiri belah salah salah salah sa Tanggaran		
Carpal Tunnel Surgery	C Left	Right	Both	er er er en		
Rotator Cuff Repair		Right	S Both			
Arthroscopic Shoulder Surgery	C) Left	Right	Both	rosantino espojeno relevente etan leminakantino monte espeta		
Hip Fracture & Surgery	C Left	Right	Sotti Both	Barana and Andrewski and Andrewski and a service of the service of		
Total Hip Replacement	C Left	Right	Both	embled on the second of the second construction of the content of the comment of the comment of the second of the		
Total Knee Replacement	Left Control	Right	Both	to a single factor of the original of problems of collections and the factor of a collection of the co		
tion of the control o	ar and carrier and the contract of the contrac	remaining the community of the community	and the second of the second o	. An and well countries to word correct to be out there are served to say the countries when		
Arthroscopic Knee Surgery Foot Surgery	こ Left こ Left	Right Right	Both     Both	t and a death the state of state and an adding standing of physical and a second conjugate of physical particles		
Varicose Vein Procedure	C Left	Right	Both	terminales en emperaturatura en mais en		
Mastoidectomy	C Left	C Right	O Both	the specific and an extra control and handle of the specific flat from the specific flat of t		
WIASLUIUECTOMY	Angelon Colonia de la Colonia	was a series of the series of	O DOUT	رسوريس بروري سر معاوره في والمشاهدة والمستحددة والمعادية والمعادة والمعاددة والمعاددة والمعادة والمعادية		
Thyroid Removal	C. Left:	C Right	∴ Total	Partial		
		And the second s		and a common common common and a state of the common common common common common common common common common c The common		
Breast Biopsy	Left	C) Right	C Both	Multiple time		
Carotid Artery Surgery	C Left	Right	C Both	Multiple time		
Open Inguinal Hernia Surgery	C Left	C Right	Soth	O Multiple time		
Laparoscopic Inguinal Hernia Surgery	C Left	C Right	○ Both	Multiple time		
Caesarean Section	1		○ 3 or more	e kunner et Mether et 1980en – Mondrett et kanne kan kon kon kon kon en europeia. Et kon et ko		
Heart Valve Replacement	Mitral	Aortic	C Tricuspid	O Unknown Valve		
The back provided the second s	◯ 1 vessel	2 vessels	3 vessels	4 or more vesse		
Heart Bypass Surgery	C Unknown num		** ** ** **			