Patient Data Sheet

Name: Last_____ First_____MI_____ Date:_____

DOB: _____/ _____/ _____ Age:_____ SSN:_____ / _____ /_____ **Marital Status:** S / M / W / D / Sep.

Address:_____ City:_____ State:_____ Zip:_____

***Race:** **(Please Circle)** American Indian / Asian / Black / Native Hawaiian / Other Pacific Islander / White / More than one race / Refuse to Report

***Ethnicity:** **(Please Circle)** Hispanic or Latino / NOT Hispanic or Latino / Refuse

***Language:** _____ **Have Living Will:** **(Please Circle)** Yes or NO

Home Phone:(____) _____ Cell:(____) _____ Work:(____) _____

Employer:_____ Position:_____ Email:_____

How May We Contact You: Home_____Cell_____Work_____Voicemail_____Text Message____Email____

May we leave test results on any of the following: Home___Cell___ Work___Voicemail___ Text Message__Email___

Spouse's Name:_____ Spouse's Employer:_____

Spouse's Cell Phone:(____) _____ Spouse's Work Phone:(____) _____

Pharmacy:_____ **Phone:**(____) _____ **City**:_____

Patient Signature:_____ Guarantor Signature:_____

Insurance/Guarantor Information

Primary Insurance Coverage:_____ Policy #:_____

Policyholder/Guarantor Name_____SSN_____DOB____/____/_____

Nearest Relative / Friend (not living with you) to notify in case of an emergency

Name: _____ Relationship: _____

Home Phone:(____) _____ Cell:(____) _____ Work:(____) _____

Address:_____ City:_____ State:_____ Zip:_____

Another Name: _____ Relationship_____

Home Phone:(____) _____ Cell:(____) _____ Work:(____) _____

Primary Care Physician Information

Primary Care Provider: _____ Phone:(____) _____

Referring Physician: _____ Phone:(____) _____

Review of Systems

Name: _____ DOB: ____ /____/____ Age: _____ Date:____/____/____

I AM HERE TODAY FOR:_____

*****Patient Signature:** _____

Please circle any of the symptoms below that pertain to your CURRENT CONDITION:

GENERAL: Fatigue, Fever, Weight Gain , Weight Loss

SKIN: Acne, Changes in Pigmentation, Jaundice , Hair Loss, Itching, Psoriasis, Rashes, Suspicious Skin Lesions

HEENT: Chronic-Sinusitis, Dizziness, Double-Vision, Earaches, Ear-Discharge, Headaches, Excessive-Tearing, Hearing-Loss, Nasal-Discharge, Nosebleeds, Oral Ulcers, Ringing-in-the-Ears, Trauma, Trouble-Swallowing, Visual-Changes

NECK: Goiter, Swelling, Stiffness, Tenderness

BREAST: Lumps, Nipple-Discharge, Pain, Tenderness,

RESP: Asthma, Cough, Coughing-up-of-Blood, Chronic-Bronchitis, Pneumonia, Shortness-of-Breath, Do you Smoke: YES or NO,
*****If YES: How Much:**_____

CV: Chest-pain, Edema, Exercise-Intolerance, Heart-Failure, Heart Murmur, Sudden-Shortness-of-Breath-While-Sleeping-or-Laying-Down-Flat, Palpitations

Office Use Only

Onset: _____

Location: _____

Timing: _____

Severity: (Pain Intensity) Scale 1-10 _____

MEDS: _____

Associated: Activity, BM's, Menses, Sex, Standing, Phys. Act, Voiding, Walk
_____

Quality: Cramping, Dull, Pressure, Sharp, Stabbing, Throbbing, _____

GI: Abdominal-Pain, Appetite, Black-Tarry-Stools, Blood-in-Stools, Change-in-Stool-Size, Constipation, Diarrhea, Diverticular-Disease Poor-, Nausea, Vomiting, Vomiting-Blood

URINARY: Burning, Blood-in-Urine Frequency, Incontinence, Leaking-of-Urine-with-Cough-or-Sneeze, Urgency, Overactive-Bladder. Describe_____

REPROD: Last Menstrual-Period_____ /_____ /_____. Abnormal-Bleeding , Itching , Pain-with-Intercourse, Painful-Periods, Pelvic-Pain, Vaginal-Discharge, Vaginal-Pressure, Contraception:_____

MS: Gout , Joint-Pain, Muscular-Weakness, Swelling

HEM: Abnormal-Bruising, Anemia, Bleeding-Disorders, Blood-Transfusions, Hepatitis, HIV

NEURO-PSYCH: Anxiety, Depression, Difficulty-with-Speech, Fainting, Gait Disturbance, Mood-Swings, Paralysis, Seizures, Psychiatric-Care, Mental-Status-Changes, Thoughts-of-Suicide,

OTHER SYMPTOMS: _____

Office Use Only
Nurse Initials:

When was your last:

	Yes	No	Dates Completed
Colonoscopy			
Mammogram			
Pap Smear			
Bone Density			

Recent Immunizations:

	Yes	No	Dates Completed
HPV			
Influenza (Flu)			
Pneumonia			

Review of Systems (part 2)

Name: _____ Date_____

List all Current Medications (***including all Vitamins, or Herbal***)

Medication	Dosage	Times per Day	Illness / Problem

Please list any **Drug Allergies**. Please include specific reaction:

Medication:		Reaction:	
Medication:		Reaction:	
Medication:		Reaction:	

Please list any **Allergies (Food, Environmental, or other)**:

-	Reaction:	
-	Reaction:	
-	Reaction:	
If you have NONE please check mark box ☐		

Please indicate any changes in your **Personal**, **Family**, and or **Social** history:

A)Have you had any recent:	(B) Any changes in Family History	(C) Social
☐ Hospitalizations ☐ Illness ☐ Surgeries ☐ Traveling ☐ No Change *Other_____	☐ Health Status/Cause ☐ death of parents siblings, &/or children (specific diseases related) ☐ No Change *Other_____	☐ Alcohol / Drug/Tobacco Use ☐ Current Employment ☐ Marital Status ☐ Sexual History ☐ No Change *Other_____

Please identify any **Physicians** that you have been recently seen by:

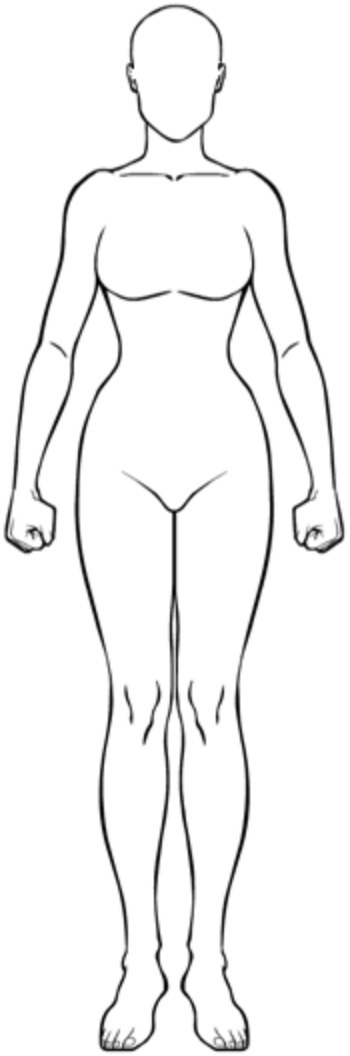
Date Seen:	Physician:	Specialty:	City:	Hospital Affiliation:

Any other problems you wish Dr. Smith to know about: _____

Name: _____ Date_____

***Please complete the survey below based on your **Current Pain Level**:

Pain Location: Place an **X** on the diagram on every area you are experiencing pain.



Pain Radiation: Draw an arrow in the direction the pain is radiating from the **X** marked on the diagram. If it's NOT radiating then, go to the next step.

Pain Quality: Please **Check Mark** all that apply to your pain.

Sharp	___	Dull	___	Aching	___
Burning	___	Shooting	___	Stinging	___
Stabbing	___	Throbbing	___	Other:	_____

Pain Scale: Enter a number from 1-10_____(Please refer to illustration below)

Pain Progression: Circle one below:

Unchanged Improved Worsening Resolved

Onset of Pain: When did the pain start? Date and Time: _____

Pain is Relieved By:

Check all that apply:

Rest	___	Ibuprofen, Advil	___	Herbal	___
Heat	___	Tylenol	___	Lortab, Demerol	___
Meditation	___	Pamprin, Midol	___	Other:	_____

Pain is Bothered By:

Check all that apply:

Standing	___	Physical Activity	___	Constipation	___
Sitting	___	Intercourse	___	Urinating	___
Walking	___	Menses	___	Bowel Movement	___

Patient History (part 1)

Name: _____ Date_____

Do you **now have-or-have you ever had**, in the past any of the following. Please tell us if you have a **family history** of the same conditions. Please indicate with a checkmark.

Office Use Only
Nurse Initials:

Diagnoses:	Personal History	Family History	Which Family Member
Alcohol Use			
Asthma			
Blood-clots in Leg / Lung			
Blood Transfusion			
Cancer			
Diabetes			
Epilepsy			
Gonorrhea (GC "Clap")			
Growths			
Heart Disease			
Herpes			
High Blood Pressure			
Kidney Disease			
Mental Illness			
Pneumonia			
Psychological			
Rheumatic Fever			
Scarlet Fever			
Syphilis			
Thyroid Disease			
Tuberculosis			
Tumors			
Urinary Infection			
Varicosities			
Other V.D. (S.T.D.)			
Other:			

Past Treatments:	YES	NO	Comments/Dates & Responses for Treatments
Chemo Therapy			
Radiation Therapy			
Serious Accident			
Hospitalizations			
Operations (Please List)			

Patient History (part 2)

Name: _____ Date_____

Social History:

	Currently Using: **(Please Circle)**	**Start Date**	**Quit Date**
Exercise	Yes - NO - Sometimes		
Alcohol Use	Yes - NO - Sometimes		
Tobacco Use	Yes - NO - Sometimes		
Illicit Drug Use	Yes - NO - Sometimes		

Menstrual History: (If you still have your uterus)

Age of first Cycle:	
Cycle (monthly, irregular):	
Duration (# of days):	
Flow (1-10 Scale):	
Pain (1-10 Scale):	
Quality (sharp, cramps):	

Recent Menstrual Cycle:

Date of Last Menstrual Cycle:	
Cycle (monthly or irregular):	
Duration (# of days):	
Date of previous cycle:	
Do you bleed between cycles:	
Do you bleed w/ intercourse:	
Are you Pregnant:	Yes - No
Age of Menopause:	
Had a Hysterectomy:	Yes - No

Obstetrical History (If applicable):

Total number (#) of Pregnancies:	
# of Term Pregnancies:	
# of Premature Pregnancies	
# of Living Children	
# of Abortions	
Age of Youngest Child	
Age of Oldest Child	
Complications w/ any deliveries	
Problem with Infertility:	

Current Contraceptive Usage (Please Circle):

Condoms, Diaphragm, Foam , IUD, Implant, Patch, Pills, Ring, Other:_____
Sterilization: Hysterectomy, Tubal-Ligation

Gynecologic Testing:

Date of last Pap Smear:	
Date(s) of any abnormal Pap(s):	
Date of Hepatitis B Shot:	
Monthly Self Breast Exam	Yes - No

Cervical & Vaginal Cancer High Risk Factors	
Sexually active before 16	Yes - No
Currently sexually active	Yes - No
# of Partners in past 12 months	
Have had 5 partners or more	Yes - No
History of STD including HIV	Yes - No
Exposed to Diethylstilbestrol in utero	Yes - No
Cervical CA in the last 3 years?	Yes - No

Office Use Only
Nurse Initials:

HIPAA

Name: _____ Date_____

Benefits to Physician

I (the patient) hereby authorize payments to be made directly to the physician of the surgical and/ or medical benefits. Please note that if you are not the Primary Insured, i.e., your coverage is through a spouse or parent, that person MUST sign this form with you. **I also understand that I / We are financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be a valid as the original.**

Consent for Treatment

I (the patient) consent to the treatment indicated on my examination for, including the use of anesthetics, biopsies, sedatives, colposcopy, x-ray, lab, injections, or pathology consultations as may be deemed necessary by the physician.

Release of Confidential Information

I (the patient) hereby authorize the release of information for insurance claims purposes, consulting physicians, and hospital medical records. Photostat of the above is as valid as the original. I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I understand there is a standard photocopying charge of a $1.00 for the first page and $0.50 for each additional sheet that may apply to the requesting party only.

My signature below acknowledges I have completely and thoroughly read understand the above, Benefits to Physician, Consent for Treatment, and Release of Confidential Information and intend to be legally bound hereby.

Patient's Signature: _____ Date: ___/___/___

Spouse / Primary Insured's Printed Name: _____

Spouse / Primary Insured's Signature: _____Date: ___/___/___

Please indicated below the following **Individuals / Organizations** you would like your medical information released to:

Name:	Contact Number:

USE & DISCLOSURE of the Health Information For Treatment, Payment, or Healthcare Operations.

I understand that as part of my health and medical care, Dr. Jeffrey Smith originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for a third-party payer to verify that services were billed as actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Dr. Jeffrey Smith reserves the right to change the notice and mail a copy to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Smith is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you that the information authorized for release may include records, which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Patient Signature: _____ Date:_____

Patient Print Name: _____

I (the Patient) request the following **RESTRICTIONS** to the use &/ or disclosure of my health information:

_____

_____

_____

_____

_____

_____

_____

_____

Office Appointments

Name: _____ Date_____

It is very important that you keep your schedule appointments when they are made. We do understand that sometimes things happen which cause you to reschedule or cancel your appointment. However we do require a 48-hour notice on all **cancellations** in order to make sure that all patients who need to be seen can be scheduled. Effectively immediately, we are implementing a **$25.00** service charge for all patients who fail to show up for their appointments without notifying the office. We are also implementing a **$25.00** service charge for all patients that arrive 20 minutes or more late to their scheduled appointment.

Financial Policy

We accept and bill most major insurance plans and in order to continue this service we ask that you comply by checking with your insurance carrier to make sure we are a participating provider before your appointment. We also ask that you comply with your insurance's pre-certification, prior-authorization, and co-pay mandates. Please keep our office informed of any changes in your personal, billing, or health information.

We ask that all co-pays, deductibles, and co-insurances are paid at the time of service. If surgery is scheduled we ask that deductibles and co-insurances are received prior to the date of surgery. We accept cash, money orders or credit card as forms of payments. We no longer accept personal checks.

For example if you have a co-pay of $25.00 you will be expected to pay that amount at every office visit. Also, if you have a $1000.00 deductible and you have not met your deductible for the year you will be expected to pay the amount in full before surgery. Most insurances pay at 80% until your Out of Pocket is meet. Out of Pockets typically range from $2,000 to $6,000 depending on the insurance company. And so you will be responsible to pay the co-insurance of 20% up until your Out of Pocket is fully meet.

- FMLA, disability (any kind), cancer policies, or any other paperwork that you need filled out or signed require a **$25.00** fee for completion. **The fee has to be paid prior to completion of paperwork. Paper work must be picked up or it can be emailed to you. Our office will not fax paperwork or be responsible for turning it in. If addendum or an update is needed another $25 fee will apply.**

- Returned checks result into a **$40.00** fee for each returned check. This must be paid along with the amount of the original check by cash or credit card. Any returned checks not paid in a timely manner will be submitted to the District Attorney's office.

- Need a copy of your Medical Records? In accordance to Title 76 torts Section 19, there is a fee for copying for any medical records for you. The fee is **$1.00** for the first page and **$.50** cents per page thereafter.

- Prescriptions not obtained during an office visit require a **$10.00** handling charge per prescription. If a prescription is lost, there will be a **$10.00** fee to rewrite it. These charges are not billed to your insurance and are the patient's responsibility.

- Surgery Cancelation Fee: If you schedule surgery and pre-op has been performed and you choice to cancel surgery there is a **$50.00** fee. If you cause surgery to be cancelled there is a **$50.00** fee. If you choose to move your surgery day and pre-op has already been preformed there is a **$25.00** fee.

My signature below acknowledges I have completely and thoroughly read understand the above, Office Appointments and Financial Policy and intend to be legally bound hereby.

Patient's Signature: _____ Date: ___/___/___

Medical Malpractice Arbitration Agreement

In consideration of the agreement of Jeffrey J. Smith, M.D., Jeffrey J. Smith, M.D., P.C., Bella Vita Med Spa and Smith Cosmetic Surgery Center and his employees, herein called the physician, to render certain medical and surgical services for hereinafter named patient, physician and patient to hereby agree as follows:

(1) It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by the laws of the State of Oklahoma, Title 15, Oklahoma Statues, Section 801, et seq., and not by a lawsuit or resort to court process except as the law of the State of Oklahoma provides for judicial review of arbitration proceeding, both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

(2) In the event of any claim, demand, controversy, civil action or dispute, including but not limited to personal injury, malpractice, or any tort, whether brought in tort, contract or otherwise, by Patient, his dependents, whether or not minors, heirs at law, or person representatives, against Doctor or any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors in interest, assigns, staff physicians or associates agreeing in writing to be bound by this arbitration provisions of the agreement ("Affiliates") ***THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION*** in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to a sole Arbitrator who is a medical doctor and a member of the American Academy of Cosmetic Surgery who shall decide the controversy based on the evidence presented. The arbitrator will be agreed upon by mutual consent of the parties. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be interviewed or joined.

(3) The prevailing party in any arbitration pursuant to this agreement shall be awarded all cost, including reasonable attorneys' fees and the arbitrators' fees, in prosecuting or defending the claim in arbitration, but not to exceed $2000.00 in amount. Furthermore, if any action is initiated or undertaken to set aside or otherwise attack this arbitration agreement or award, or to compel arbitration, the prevailing party in the court action shall be entitled to all costs of such action, including reasonable attorney's fees as may be fixed by the court.

(4) Any party initiating arbitration under this agreement shall file with his petition a bond or cash surety in the amount equal to One Thousand Dollars ($1,000.00), which shall provide security for attorney's fees and costs in the event that the moving party should not prevail.

(5) Any party initiating a complaint, critical of the other, via a public media, such as internet, TV, radio or print forum, agrees to pay the other party $1,000 and costs to correct the infringement.

(6) In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision or provisions shall be stricken and shall be of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity.

(7) This agreement shall not limit the ability of the physician, who is or is not covered by malpractice insurance, in the exercise of his professional judgment, to refer the patient to other physicians or to decline further medical treatment to the patient.

(8) This agreement shall be construed in accordance with and governed by the law of the State of Oklahoma.

Medical Malpractice Arbitration Agreement

This is a binding LEGAL DOCUMENT, which may have an important effect on your legal rights. This agreement provides that all medical controversies shall be decided by an arbitrator agreed upon mutually. Consult your attorney on any questions that you may have.

NOTICE: **By signing this contract you are agreeing to have any medical issue decided by neutral arbitration** and you are giving up the right to a jury or court trial. Please See ARTICLE ONE (1) of this contract.

Dated this_____day of _____,20_____

_____

Jeffrey J. Smith, M.D. Signature

_____

*****Patient Signature***

_____

Witness

_____

Witness

State of Oklahoma)

) ss.

County of Oklahoma)

*I, _____, (**Patient Name**) of lawful age, being first duly sworn, upon oath, state that I am the patient above named; that I have read the foregoing MEDICAL MALPRACTICE ARBITRATION AGREEMENT; that I am familiar with the contents thereof and understand the same; and have been afforded the opportunity for legal counsel prior to the signing thereof.*

_____

*****Patient Signature***

Before me, the undersigned, a notary public, personally appeared_____,

And acknowledged to me that he/she executed the foregoing as his/her own free will.

_____

Notary Public Signature

_____

Commission Number

_____

Commission Expires