HPI PHYSICIANS, LLC.

300 NW 32nd Street • Newcastle, Oklahoma 73065 • (405) 387-3323 • FAX (405) 387-4275
Megan A. Hanner, D.O.

NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX:	BIRTH DATE:	AGE

SOCIAL SECURITY NO.:	MARITAL STATUS: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	SPOUSES NAME:	RACE:

PATIENT'S ADDRESS:			REFERRING PHYSICIAN:	ETHNICITY:
CITY:	STATE:	ZIP CODE:	Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired	PREFERRED LANGUAGE:
HOME PHONE: ( )	WORK PHONE: ( )		CELL PHONE: ( )	

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company _____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient _____

Not Applicable ❑ Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

EMPLOYMENT INFORMATION

Patient's Employer _____ Ph# _____

Insured Employer _____ Ph# _____

If the patient is a minor, please list both parents names and employer

Mother _____ Employer _____ Ph# _____

Father _____ Employer _____ Ph# _____

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:	
HOME PHONE: ( )	RELATIONSHIP TO THE PATIENT:

THIRD PARTY BILLING

Is Your Injury Work Related?	❑ Yes	❑ No
Is This Injury Due To An Accident?	❑ Yes	❑ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	❑ Yes	❑ No

I Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the HPI Physicians, LLC Privacy Notice.

Signature _____ Date _____

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

Today's date: _____

Medical History Form

Review of Systems

Are you experiencing any of the following symptoms?

General:
- ☐ Chills
- ☐ Excessive Weight Gain/Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness

Skin:
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives
- ☐ Jaundice
- ☐ Rash

HEENT:
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Visual Changes
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Postnasal Drainage
- ☐ Sinus Pressure
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat

Respiratory:
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Difficulty Breathing on Exertion
- ☐ Palpitations
- ☐ Swelling of Extremities

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Groin Pain
- ☐ Incontinence
- ☐ Pelvic Pain
- ☐ Urgency

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Stiffness

Neurologic:
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures
- ☐ Syncope
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble Focusing

Endocrine:
- ☐ Excessive Thirst
- ☐ High Blood Sugar
- ☐ Low Blood Sugar

Hematology:
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Nodes

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Past Medical History

Heart
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Beat
☐ Atrial Fibrillation
☐ Other_____
_____

Lungs
☐ Asthma
☐ COPD
☐ Emphysema
☐ Other_____
_____

Dermatology
☐ Skin Cancer
☐ Acne
☐ Rash

Psychiatric
☐ Memory Loss/Confusion
☐ Anxiety
☐ Depression
☐ Bipolar

Stomach
☐ Reflux
☐ Heartburn
☐ Ulcers
☐ Bleeding
☐ Irregular Bowel
☐ Diverticulitis
☐ Liver Disease
☐ Hepatic Failure
☐ Other_____

Musculoskeletal
☐ Arthritis
☐ Gout
☐ Broken Bones
☐ Other_____
_____

Urology
☐ Kidney Stones
☐ Prostate Issues
☐ Other_____

☐ Cancer: List What Type
_____
_____
_____

Endocrine
☐ Diabetes Type I
☐ Diabetes Type II
☐ Gestational Diabetes
☐ Thyroid
☐ Other_____
_____
_____
_____

Neurologic
☐ Stroke
☐ Headache
☐ Migraine
☐ Dementia
☐ Seizures

Gynecology
☐ Endometriosis
☐ HPV

Other
☐ Anemia
☐ Sinus & Allergy
☐ Other _____

Social History

Tobacco: ☐ Never
☐ Current: Cigarettes ☐ Yes ☐ No Amt:_____ _____pck/day Has been smoking for? _____
Smokeless Tobacco ☐ Yes ☐ No Amt:_____per day
Cigars ☐ Yes ☐ No Amt:_____# week
☐ Quit: Year last smoked _____ Amt: _____pck/day How many years did you smoke?_____
Children: Secondhand smoke exposure? ☐ Yes ☐ No
Alcohol use:☐ Yes ☐ No _____# drinks per day / week / occasional / social
Caffeine use: ☐ Yes ☐ No _____# drinks per day / week / occasionl / social
Seatbelt use: ☐ Yes ☐ No
Exercise: ☐ Yes ☐ No Times per week: _____ Type of exercise: _____
Occupation: _____ _____
Have you ever used **street drugs**: ☐ Yes ☐ No Which ones: ☐ Marijuana ☐ IV drugs ☐ Cocaine
☐ Amphetamines ☐ Heroin ☐ Downers ☐ Inhalants ☐ other _____
Are you still using: ☐ Yes ☐ No Which ones: _____
Are you sexually active (in the last year)? ☐ Yes ☐ No ☐ Never
If yes check all that apply: ☐ 1 Partner ☐ Multiple Partner ☐ Male Partner(s) ☐ Female Partner(s)
☐ 5 or More Partners in your Lifetime
Which birth control do you use? ☐ None ☐ Condoms ☐ The Pill ☐ Vasectomy/Tubal ☐ Other_____
Is there concern for your safety? ☐ Yes ☐ No ☐ Emotional ☐ Physical ☐ Sexual Abuse

Patient Name: _____ _____ DOB: _____ Entered by: _____ Audited: _____

Family History

Have any of your family members had any of the following problems?

☐ Alcoholism	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Asthma	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Breast Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Colon Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Depression	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Elevated Lipids	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Attack	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Lung Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Migraines	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Osteoporosis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Ovarian Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Skin Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Thyroid Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Uterine Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Diagnosis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Other_____

List all **ALLERGIES** to any medications **and** the reactions: ☐ No Known Drug Allergies

Medication	Reaction	Significance
		☐Major ☐Moderate ☐Minor
		☐Major ☐Moderate ☐Minor
		☐Major ☐Moderate ☐Minor
		☐Major ☐Moderate ☐Minor
		☐Major ☐Moderate ☐Minor
		☐Major ☐Moderate ☐Minor
		☐Major ☐Moderate ☐Minor

IMMUNIZATIONS: **(List Dates)**

Hepatitis A: _____
Hepatitis B: _____
Td- Adult Tetanus Toxoid: _____
Influenza: _____
Pneumovax: _____
PPD – Tuberculin Skin Test (Include Results): _____
Gardasil (HPV): _____
Zostavax: _____

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

CURRENT MEDICATIONS: (Please include over the counter medication and food supplements.)

Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
☐ None

Pregnancy and Birth

Date of Last Menstrual Period: _____ Age of First Period: _____
# of Days In Flow: _____ # of Days Between Cycles: _____
Are you Menopausal ☐ Yes ☐ No Age at Onset Of Menopause: _____
# of Pregnancies: _____ # of Live Births: _____ # of Abortions _____ # of Miscarriages _____
# of Living Children _____

Past Surgical History

Please check or list all of the SURGERIES you have had:

Type of Surgery	Year
☐Appendectomy	
☐Arthroscopy (joint)	
☐ Back Surgery or ☐ Neck Surgery	
☐Cataract Surgery	
☐Cesarean Section	
☐Gallbladder Removal	
☐Heart Surgery (Specify)	
☐Hemorrhoids	
☐Hernia (Specify)	
☐Hysterectomy	
☐ Knee Replacement or ☐ Hip Replacement	
☐Mastectomy or Lumpectomy (Specify)	
☐Polyp Removal (Colon)	
☐Tonsillectomy or ☐ Adenoidectomy	
☐Tubal Ligation or ☐ Vasectomy	
☐Plastic Surgery (Specify)	
☐Other (Specify)	
☐Other (Specify)	
☐Other (Specify)	

Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Have you had any orthopedic complaints resulting in radiology procedures in the last year?
(ex: Xray, MRI, CT scan)

Radiology Procedure	Year

Health Maintenance

Date of last Mammogram: _____(mo/yr) Date of last Bone Density: _____(mo/yr)
Date of last Colonoscopy: _____(mo/yr)
(Diabetic Patients) Date of last Eye Exam:_____(mo/yr) Where: _____
FOR WOMEN: Date of last Pap Smear: _____(mo/yr)
FOR MEN: Date of Last PSA level drawn (Prostate Cancer Screening):_____(mo/yr)

Please provide **first & last** names of all other physicians that you currently see and their specialty:

_____

_____

*What is your preferred pharmacy (Please include name and phone number and/or location):_____

_____

What is your preferred mail order pharmacy (Please include name and phone number): _____

_____

Patient Signature: _____ _____
Date: _____

AUTHORIZATION FOR TREATMENT

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

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of HPI Physicians, LLC 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 HPI Physicians, LLC 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, workers compensation carriers, welfare funds, the Social Security Administration or its 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 AS 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 HPI Physicians, LLC, its agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at HPI Physicians, LLC. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing for fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release HPI Physicians, LLC from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ DATE _____

(PATIENT)

OR _____

(NEAREST RELATIVE OR RESPONSIBLE PARTY)

_____ POLICYHOLDER'S SIGNATURE _____

(RELATIONSHIP TO PATIENT)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made a confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.

HPI Physicians, LLC

A division of The Physicians' Group

Financial Policy

Thank you for choosing "HPI Physicians, LLC" as your healthcare provider. At HPI Physicians, LLC we are dedicated to providing the highest quality, most cost effective care specializing in Family Medicine.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous, Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different and constantly updating providers participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior-authorization and pre-certification processes. Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring to each appointment your current insurance card, or any other information that is required by your insurance carrier. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible, and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover Card, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our billing department, at 405 419-8444 to make payment arrangements. Please be aware that charges for physical therapy, durable medical equipment, pathology services, laboratory testing, and some radiology services may be billed separately.

We are able to do the majority of lab testing here at our facility, however your insurance carrier determines which labs are covered under your policy. We do require that all Non-HMO patients pay 30% of total lab charges performed in our lab. This payment of lab services is due at the time of service.

There is a $35.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

Again, thank you for allowing HPI Physicians, LLC to participate in your care.

My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date _____

(Signature of person financially responsible for payment)

Relationship if other than patient: _____

Chart No. _____

HPI Physicians, LLC

Authorization to Release Information via phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of HPI Physicians, LLC regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____ Cell phone: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature Date

HPI Physicians, LLC STAFF ONLY:

Documented by:

_____ _____

Initials Date

HPI Physicians, LLC

A division of The Physicians' Group

MEDICATION REFILLS

1. Refill requests may be made Monday-Friday, 8:00 am to 4:00 pm. Please have the pharmacy fax refill requests to 387-4275.

2. Refills *will not* be made after hours, at night, on weekends or holidays. On call physicians will not answer calls regarding medication refills.

3. Prescriptions that cannot be called in (i.e. Adderall) require a *3-day notice* to be refilled.

4. If the prescription is to be picked up, you may do so Monday-Friday, 11:00 am to 12:00 noon or 4:00 pm to 5:00 pm.

5. Please check your bottles for refills. If you have refills you *do not* need to call the doctor's office, only call the pharmacy.

6. Patients are responsible for their controlled substance medication. Your doctor will closely monitor controlled substance medication.

7. Please remember to discuss any medication concerns you have with your doctor at your regular scheduled appointments.

8. Please be aware we do not always have medication samples in stock.

9. Our office hours are Monday-Friday, 8:00 am to 12:00 noon and 1:15 pm to 5:00 pm.

10. After hours or in case of emergency, you may call 387-3323 and you will be given instructions on how to contact the doctor on call.

Patient signature:_____ Date:_____

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. Megan A. Hanner has an ownership interest in Community Hospital and Northwest Surgical Hospital. SSM Health Care of Oklahoma d/b/a St. Anthony Hospital is also a proud affiliate of 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 communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand 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

Date:_____

Community Hospital at Penniston Park | Community Hospital OUTPATIENT THERAPY | Community Hospital at St. Anthony North

Northwest Surgical Hospital | LakePointe Imaging Center

REQUEST FOR THE RELEASE OF MEDICAL RECORDS

Date:_____

Patient Name:_____Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

I hereby give the following my permission to release my medical records:

Dr:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

Please release my entire medical records to the following:

Name: Dr. Megan A. Hanner, D.O.

Address: 300 NW 32nd Street

City: Newcastle State: Oklahoma Zip: 73065

Phone: 405 387-3323 Fax: 405 387-4275

Notice to Patients: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release to person who have had risk exposures, release pursuant to an order of the court of the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health by law.

_____ _____

Patient Signature Date

Meaningful Use Reporting Requirements

Pt Name: _____ Date of Birth: _____

(Please check all that apply.)

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Refused to Report/Unreported

RACE

☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ American Indian or Alaska Native

☐ Multiple ☐ Native Hawaiian or Other Pacific Islander

☐ Refused to Report/Unreported

PREFERRED LANGUAGE

☐ English ☐ Spanish

☐ Chinese ☐ Japanese

☐ Filipino ☐ Vietnamese

☐ French ☐ Other-Please Specify:

☐ German _____