OFFICE VISIT CHECKLIST

- ☐ **Please arrive 20 minutes early to your appointment for check in.**

- ☐ Bring your insurance cards to your appointment, everytime.

- ☐ It is your responsibility to understand your insurance coverage.
  - Which physicians are covered in your plan?
  - What are your co-pay amounts for office visits?
    - You may pay your co-pay at the time of your visit.
    - Cash, check or credit card is accepted.

- ☐ Questions about your insurance?
  - Call your employer's Human Resource Department or the telephone number on your insurance card.
  - Every health care plan varies based on your employer.

- ☐ Review your pharmacy benefits.
  - Do you need a 30 day or 90 day prescription?
  - Should you have generic versus brand name medications.
  - What pharmacies can you use?
  - Is the medication on the formulary?
  - Do you need prior authorization?

OakLeaf CLINICS

Thank you for choosing OakLeaf Clinics!
To better care for you, we need the following information.
Please Print. All information will be confidential.

PATIENT INFORMATION

Patient's Legal Name (Last): _____ (First): _____ (MI): ____

Preferred First Name: _____ Maiden Name/Previous Names: _____

SSN: _____ ☐ Male ☐ Female Birthdate: _____

Address: _____ City: _____ County: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please check one: ☐ Minor ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated

Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other_____ ☐ Decline

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline

Race: ☐ White ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American
☐ American Indian ☐ Native American or Alaska Native ☐ Decline

Who is your Primary Care Physician/Provider? _____

Employer: _____ Work Phone: _____

If patient is a student, name of school/college: _____

If married, Spouses' Name: _____ Phone: _____

If Minor, Parents' Name: _____ Phone: _____

Parents' Address: _____ City: _____ County: _____ State: ___ Zip: _____

If Minor, Parents' Name: _____ Phone: _____

Parents' Address: _____ City: _____ County: _____ State: ___ Zip: _____

Emergency Contact Name: _____ Relationship:_____Phone: _____

Who may we thank for referring you?_____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Birthdate: _____Employer: _____ Work Phone: _____

INSURANCE INFORMATION *(Required unless you are self-pay.)*

Primary Insurance: _____ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder's Address: _____

Employer: _____ Work Phone: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Effective Date: _____

Secondary Insurance: _____ID # _____Group #_____

Policy Holder: _____ Policy Holder's Address: _____

Employer: _____ Work Phone: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Effective Date: _____

PAST MEDICAL HISTORY: *Please check all that apply*

	Arthritis		Kidney Disease/Problems		Anemia
	Diabetes		Radiation Therapy		Chemotherapy
	Blood Clots		Rheumatic Fever		Jaundice (Yellowing of Skin)
	Heart Attack/Chest Pain		Tuberculosis		Sinus Problems
	Stroke		Bleeding Tendency		Pneumonia
	Transfusions		Bronchitis		Asthma/Wheezing
	Thyroid Disease/Goiter		High Blood Pressure		Emphysema
	COPD		Congestive Heart Disease		Nervous Breakdown
	Chicken Pox or Immunization		High Cholesterol		Depression
	Cancer		Valve Replacement		Joint Replacement
	Heart Murmur		Difficulty Sleeping		Headaches
	Excessive Fatigue		Weight Loss/Gain		Moles that Have Changed
	Heartburn		Constipation		Diarrhea
	Black Tarry Stools		Recurrent Stomach Pain		Bladder Control/Leak
	Vaginal Discharge (Itching/Burning)		Difficulty Swallowing		Sores in the Mouth
	Long-Term Back Pain		Swollen Painful Joints		Swelling of Feet/Ankles

Please describe any other medical problems not listed above:

_____

_____

_____

PREVIOUS HOSPITALIZATIONS	**Year**	**PREVIOUS SURGERIES**	**Year**

FAMILY MEDICAL HISTORY

Family Member	Age	Living	Major Illness
Father			
Mother			
Brothers			
Sisters			

IMMEDIATE FAMILY WITH ANY OF THE FOLLOWING:

	Cancer		Alcoholism
	Goiters		Allergy
	Kidney Disease		Bleeding Tendency
	Tuberculosis		Asthma

ALLERGIES	**REACTION**
Non-Drug	
Drug	
Food/Seafood	

Please list all current medications and supplements:

MEDICATION NAME	**DOSE**	**FREQUENCY**

PROCEDURES	**MONTH/YEAR**
Colonoscopy	
Mammogram	
PAP	
Bone Density	
PSA	

IMMUNIZATION	**YEAR**
Tetanus	
Flu Vaccine	
Pneumonia	
HPV	
Hepatitis B	

Check all that apply:

	Illegal Drugs		Regularly Exercise		Special Diet
	Good Support Group		Wear Seat Belts/Helmets		Alcohol Use
	Caffeine Consumption		Smoker		Chewing Tobacco

WOMEN'S HEALTH ONLY:

Medical Problems	No	Yes	Have Now	In the Past
Abnormal Pap Smear				
Procedures on your cervix				
Abnormal Bleeding				
Breast, uterine, ovarian or colon cancer				
Surgery on uterus or C-Section				
Breast cysts, lumps, biopsies				
Nipple discharge				
Fibroids				
Night sweats, hot flashes				
Pain with intercourse				
Recurrent vaginal infections				
Unable to get pregnant after trying				
Uterine abnormalities				
Verbal, physical or sexual abuse				
History of Sexually Transmitted Diseases:				
Chlamydia				
Warts (HPV)				
Gonorrhea				
Syphilis				
Herpes				
HIV/AIDS				

Please answer the following:

What was the first day of your last menstrual period?	
How old were you when you had your first period?	
How often do you get your period?	
How many days do you menstruate?	
Are your periods heavy or painful?	
When was your last pap smear?	
How many times have you been pregnant?	
How many children do you have?	
How many vaginal deliveries?	
How many C-Sections?	
How many miscarriages?	
How many elective abortions?	
How do you currently prevent pregnancy?	
How long have you been with your current partner?	

FAMILY SHARED INFORMATION

Patient Name: _____ Date of Birth: ___/___/___

I hereby consent that my healthcare information may be shared both verbally and by mail with the following individuals:

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Signature: _____ Date: ___/___/___

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Patient Name/Previous Name(s) *Date of Birth*

_____ _____
Street Address *City, State, Zip Code*

AUTHORIZES FROM:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip, Code

For the following dates: ___/___/___ to ___/___/___

INFORMATION TO BE RELEASED:

_____Medical History, Examination, Reports _____ Surgical Reports _____ Immunizations

_____ Treatment or Tests _____Hospital Records/Reports _____Radiology Reports _____ Laboratory Reports

_____Consultations _____ Other _____

In compliance with Wisconsin Statutes, to release privileged information; Please release records pertaining to:

_____Mental Health _____Developmental Disabilities _____ Alcohol & Other Drug Abuse

_____HIV (AIDS) _____Sexually Transmitted Disease Results _____Clinic Therapy (counseling) Notes

_____Mental Health Admission/Discharge Summary _____Mental Health Hospital Assessments/Notes

PURPOSE OF DISCLOSURE:

_____Further Medical Treatment _____ Legal Investigation/Action _____Personal

_____Insurance Eligibility/Benefits _____Changing Physicians

_____Other _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Oakleaf Clinic, SC. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Oakleaf Clinics, SC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records:
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CRF Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

Note: A patient (18 years or older) must authorizes the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Relationship (if not patient)

_____ _____

Witness *Date*