



Eau Claire:

3802 W Oakwood Mall Drive * Telephone 715.839.9280 * Fax 715.839.9348

Chippewa Falls:

855 Lakeland Drive * Telephone 715.839.9280 * Fax 715.726.2087

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?



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: _____ 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:

<input type="checkbox"/>	Illegal Drugs	<input type="checkbox"/>	Regularly Exercise	<input type="checkbox"/>	Special Diet
<input type="checkbox"/>	Good Support Group	<input type="checkbox"/>	Wear Seat Belts/Helmets	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	Caffeine Consumption	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	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:

OakLeaf Clinics - ECMC
Phone: 715-839-9280
Fax: 715-552-3791 for Eau Claire office
Fax: 715-720-0747 for Chippewa Falls

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 CFR 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