New Patient Information

Date: _____

DRH Health Clinics look forward to meeting your healthcare needs. To best determine how to meet your needs, we need to know about the condition which brings you here. Please list all the medications you are currently taking, including over-the-counter medication. Your healthcare provider will review all of this information, and then you will be contacted regarding an appointment.

** We will not be able to accommodate patients who only have pain management needs. **

Your Current Provider: _____

His/Her Location: _____

Your Requested Clinic: _____

Once you complete this packet, please return it to the Clinic of your choice.

Patient Full Name: _____

Address, City, State Zip: _____

_____

Date of Birth: _____ Gender at Birth: _____ Language: _____

Race: _____ Ethnicity: Hispanic or Non Hispanic

Cell Phone: _____ Home Phone: _____

Guarantor Name: _____Guarantor Date of Birth: _____

Relationship to Patient: _____

Guarantor Address, City, State Zip (if different from patient): _____

_____

*__Please provide a copy of your insurance card to the front desk at your first visit__. *

Insurance: _____

Policy#: _____ Group#: _____

By signing below, you authorize the DRH Health provider and designated employees to access the Oklahoma Prescription Monitoring Program database to review your information.

_____

Your Signature Today's Date

Medical Information

What brings you in today? _____

Current Health Diagnoses	Past Medical History	Surgical History

Allergies to Medications: _____

What Pharmacy do you prefer to use? _____

Current Medication

Please include over the counter medications and supplemeents

Name of Medication	Dosage, Frequency and Route

Authorization for Release of Medical Records*

TO: _____
_____
_____
_____

I, _____ being competent, eighteen (18) years of age or older and duly authorized, do willfuly and voluntarily authorize you to release medical records to Duncan Regional Health.

*Please see fax cover sheet for address, phone & fax number.

On _____myself _____ other _____ the complete medical record in your possession concerning overall health care, illnesses and treatments administered for the time period _____ to _____. I release you from all legal responsibility or liability that may arise from this authorization.

I further understand and acknowledge 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).

Signatue of Patient or Guardian_____ Date: _____

Date of Birth _____ Social Security Number _____

Patient's Address _____

Patient's Phone Number(s) _____

Note: If the patient is a minor or otherwise incapacitated, law requries that the legally authorized guardian or custodian authorize or consent to the release of such medical information.