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

DRH HEALTH

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.

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

CHILD'S NAME: ______________________________ DATE OF BIRTH: ________________

PERSON COMPLETING FORM/RELATIONSHIP ______________________________

DATE OF FORM COMPLETION: ______________________________

MEDICATIONS:

Medication	Prescribing provider	Dose	How many times a day

MEDICATION ALLERGIES: ☐ No ☐ Yes

If yes, to what medication(s) ______________________________

What was the reaction ______________________________

____

IMMUNIZATION HISTORY (please supply a copy of your child's immunization record):

To the best of my knowledge, my child is up to date on his/her immunizations ☐ No ☐ Yes

If no, why? ______________________________

BIRTH HISTORY:

Please indicate any medical problems during pregnancy ______________________________

Please list any medications taken during the pregnancy ______________________________

Any drug or alcohol use during the pregnancy ☐ No ☐ Yes ______________________________

Delivered by ☐ elective C-section ☐ emergent C-section ☐ forceps ☐ vacuum extraction ☐ normal vaginal delivery

Number of weeks gestation ____________

Birth weight ____________ Discharge weight ____________

Did the baby receive the Hepatitis B vaccine ☐ No ☐ Yes If yes, date given ____________

Please indicate any medical problems during the newborn period ______________________________

Name of hospital where infant was born ______________________________

HOSPITALIZATIONS:

Has your child ever stayed overnight in a hospital? ☐ No ☐ Yes

If yes, when and why? ______________________________

____

SURGICAL/OUTPATIENT PROCEDURE HISTORY: (ex: ear tubes, tonsilectomy, etc)

Please indicate any surgeries or procedures our child has had. Please include the year the surgery/procedure was performed.

____

____

____

Pediatric Medical History Form

SOCIAL HISTORY:

Is the child cared for by anyone other than the biological parents? ☐ No ☐ Yes

If yes, by whom and how frequently? ____________________

Does anyone in your home smoke? ☐ No ☐ Yes

Siblings (please note if step or half):

____

____

PERSONAL MEDICAL HISTORY:

☐ ADD/ADHD	☐ Chicken pox	☐ Headaches	☐ Liver disease/Hepatitis
☐ Allergies	☐ Concussion	☐ Hearing problems	☐ Recurrent ear infections
☐ Anemia	☐ Diabetes	☐ Heart murmur	☐ Reflux/GERD
☐ Asthma	☐ Eczema	☐ Congenital heart disease	☐ Seizures
☐ Bleeding disorder	☐ Fracture	☐ High blood pressure	☐ Urinary Tract Infections
☐ Bronchiolitis	☐ Handicaps/Disabilities	☐ Kidney disease	☐ Vision Problems

OTHER PROVIDERS: (Please list any other specialists your child sees. Ex: physical therapy, ENT, etc)

____

____

____

GYN HISTORY (if applicable):

Age of first period ________ years   Has not had menses yet ____________________

FAMILY HISTORY:

Please indicate if your child has a family history (parents, siblings, maternal/paternal grandparents, aunts, or uncles) of any of the following: ****Please specify maternal/paternal relation**

Diagnosis	Family Member	Diagnosis	Family Member
☐ ADD/ADHD	________	☐ Hearing disability	________
☐ Alcohol/Drug Abuse	________	☐ High cholesterol	________
☐ Allergies	________	☐ High blood pressure	________
☐ Asthma	________	☐ HIV/AIDS	________
☐ Birth defects	________	☐ Learning disability	________
☐ Blood disorders	________	☐ Mental illness	________
☐ Cancer, type	________	☐ Mental retardation	________
☐ Heart disease (heart attack, bypass, stents	________	☐ Migraines	________
☐ Deafness/Hearing problems	________	☐ Scoliosis	________
☐ Depression	________	☐ Seizure disorder	________
☐ Developmental delay	________	☐ Speech problems	________
☐ Diabetes	________	☐ TB/Lung disease	________
☐ Genetic disorder	________	☐ Stroke	________
☐ Hepatitis/Liver disease	________	☐ Thyroid disease	________
		☐ Other	________