

To my patients,

Welcome to my practice! This practice adheres to the principles of the Ideal Micropractice. These principles are roughly that I strive to provide you with the care you want, when you want it. I allow more time for each appointment and I work hard to provide ideal care for chronic disease management and well care. One goal of this style of practice is to help patients achieve an understanding of their illnesses and preventative care.

I see patients nearly every day if I am in town. I am available for emergencies by phone if I am not in the office. If you call my office, there is an option for emergencies; this connects you to my cell phone. Please do not hesitate to call me if you have a true urgent or emergent situation.

My goal is to offer same day appointments; sometimes it will be the next day. I am able to offer this for routine as well as sick visits. Please remember that may not mean that you can have the EXACT appointment time you want! I will try my best to accommodate you. Also, please note that the best way to ensure I will be able to offer you a same day appointment is to call me early.

I do the billing myself. It is simultaneously frustratingly difficult and achingly boring. Please forgive my mistakes and notify me immediately. I will make corrections. For those of you with deductibles or HSA's, payment at the time of service is greatly appreciated. Co pays are also due at the time of service. For people who pay in full at the time of service and choose not to have me bill insurance I offer a 50% discount. This discount applies because I do not spend the administrative time on billing. I will provide you with a detailed receipt (superbill) which you can submit to your insurer.

## Patient Information

First Name	Middle Name	Last Name
SS Number	Date of Birth	Age
Gender	Marital Status	
Address		
City	State	Zip
Student?	Work Status	Home Phone
Work Phone	Cell Phone	Email
Race	Emergency Contact	Emergency Contact Phone
Referred By:		

## Responsible Party

Self?	Yes/No	(If No, please provide details below)
-------	--------	---------------------------------------

Relationship to Patient		
First Name	Middle Name	Last Name
Address		
City	State	Zip
Home Phone	Work Phone	DOB

## Employment Details

Company Name	Start Date	
Address		
City	State	Zip
Phone Number		

### Preventive Screening

Exam	Date	Exam	Date
Last Physical Exam		Last Mamogram	
Last Eye Exam		Last Breast Exam	
Last Dental Exam		Last Pap Smear	
Last Rectal Exam		Last Chest Xray	
Last Stool Occult		Last Cholesterol Test	
Last Sigmoid/Colonoscopy		Last Thyroid Exam	

### Past History

Condition	Yes	No	Condition	Yes	No
Polio			Mumps		
AIDS			STD		
Blood Plasma Transfusion			Hepatitis		
Cancer			Depression		
Chicken Pox			Arthritis		
Epilepsy			Skin Disease		
Infectious Mono			Heart Problems		
Measles					

### Past Illness History

Illness Name	From To	Unable to work?	Result

### Past Surgical History

Surgery Name	Date	Place, Physician	Complications

### OB/GYN History

Age of Menstruation	Frequency	Duration	Men. Flow
Menstrual Pain	Pre-Men Symp	Contraceptives	Last Men Date
H/O Fibroid	H/O Ovar Cyst	H/O Endometriosis	H/O Cerv. Canc
Childbirths - When	Where	Mode of Birth	Complications
Miscarriages - Why	When	Age of Fetus	Where



## Patient Consent Form

I hereby give my consent for **Kristin L. Oaks D.O. inc.** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (**Kristin L. Oaks D.O. inc's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy prior to signing this Consent. **Kristin L. Oaks D.O. inc** reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Kristin L. Oaks D.O. inc.** at **933 High St. Suite 116, Worthington, OH 43085.**

With this Consent, **Kristin L. Oaks D.O. inc** may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this Consent, **Kristin L. Oaks D.O. inc** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked **Personal and Confidential.**

With this Consent, **Kristin L. Oaks D.O. inc** may e-mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Kristin L. Oaks D.O. inc.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this Consent.

By signing this Consent, I am consenting to **Kristin L. Oaks D.O. inc's** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, or later revoke it **Kristin L. Oaks D.O. inc** may decline to provide treatment to me.

**AGREED:**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Signature of Patient or Legal Guardian