PATIENT REGISTRATION

Last Name ____________ First Name ____________ MI ______
Address ____________ City ______ State ___ Zip ______
Home Phone ________ Cell Phone ________ Work Phone ________
Primary Care Provider ____________ Referring ____________
Date of Birth ______ Sex M F Marital Status ______ Social Security No ________
Employer ____________ City/State ______ Zip ______

RESPONSIBLE PARTY OR INSURED (If different than patient)

Guarantor Name ____________ Phone ________ Cell ________
Mailing Address ____________ City ______ State ___ Zip ______
Social Security No ____________ Date of Birth ________
Employer ________ City/State ______ Zip ______ Relationship to Patient ______

INSURANCE INFORMATION

Primary Insurance ____________ Group ________
Insurance Address ____________ Policy ID ________
Insured's Relationship to Patient ________ **IF NOT SELF, FILL OUT INFORMATION FOR RESPONSIBLE PARTY ABOVE**

Secondary Insurance ____________ Group ________
Insurance Address ____________ Policy ID ________
Insured's Name ____________ Relationship to Patient ________
Insured's Date of Birth ______ Insured's Employer ____________

Tertiary Insurance ____________ Group ________
Insurance Address ____________ Policy ID ________
Insured's Name ____________ Relationship to Patient ________
Insured's Date of Birth ______ Insured's Employer ____________

EMERGENCY CONTACT (Not living with patient)

Name ____________ Relationship ________
Home Telephone No ____________ Work Telephone No ________

OTHER INFORMATION

Primary Pharmacy ____________ City/State ________ Zip ______
Secondary Pharmacy ____________ City/State ________ Zip ______
Your Email ____________ Can we leave a message on your home phone? Y N
Can we leave a message on your cell phone? Y N
Race ________ Ethnicity Hispanic or Non-Hispanic ________ Primary Language ________

How did you hear about us? ☐ Billboard ☐ Family ☐ Friend ☐ Physician ☐ Insurance ☐ Internet Search
☐ Social Media ☐ Walk-In ☐ Other ____________

11/2019

(OVER)

Name ____ DOB: ________________

AUTHORIZATIONS

CONSENT FOR TREATMENT: I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

RELEASE OF INFORMATION: I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse, communicable disease or non-communicable disease) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare/Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

ASSIGNMENT OF INSURANCE: I authorize any insurance benefits to be paid directly to the physicians providing services to the patient, all benefits due, and payable as a result of services rendered.

FINANCIAL RESPONSIBILITY: I understand that the physician will file claims with all insurance carriers as a courtesy. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer unless there is a specific written agreement between the physician, the patient and the payer.

MONEYS OWED: I understand and agree that any credits or unappropriated money that I pay may be applied to any existing debts I owe.

MEDICARE PATIENTS: Medicare will pay only for services it determines to be "reasonable and necessary". If services that the physician has requested are denied for payment by Medicare, I agree to be personally and fully responsible for those charges.

ADVANCED DIRECTIVE: Do you have an Advanced Directive? ☐Yes ☐No
Would you like information regarding Advanced Directives? ☐Yes ☐No

ACKNOWLEDGMENTS

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how the patient's medical information will be used and disclosed by NRHS is in the "Notice of Privacy Practices". A copy has been provided to me in my registration packet and is posted in the clinical site. I have received and accepted a copy of NRHS "Notice of Privacy Practices". ☐Yes ☐No

Reason for refusal if "NO"____

PATIENT RIGHTS: I have received a copy of "Your Medical Treatment Rights Under Oklahoma Law" and "General Information Concerning your Rights & Responsibilities". ☐Yes ☐No

TELEPHONE CONSUMER PROTECTION ACT (TCPA): You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I have read this disclosure and agree that I may be contacted as described above.

____ ________________

Signature Date

CERTIFICATION: I hereby certify that I have read each of the above statements, that they are true and correct to the best of my knowledge, and I have had each item explained to me to my satisfaction. I further certify that I am the patient or duly authorized by the patient to accept and sign the agreement and accept its terms. A photocopy has the same effect as the original.

____ ______________ __________________

Signature of patient/Guarantor/Authorized Person Relationship Date Signed

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. PATIENT INFORMATION (PERSON WHOSE INFORMATION WILL BE SHARED)

Name | Date of Birth

Address | City / State / Zip

Area Code & Telephone Number

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information for reasons in addition to those already permitted by law.

A. PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE MY INFORMATION:

Name, Address	Relationship	Purpose

B. INFORMATION TO BE SHARED:

1. CHECK ONE OR MORE OF THE BOXES BELOW:

☐Entire Medical Record (includes all records except Psychotherapy Notes)

☐Psychotherapy Notes

☐Mental Health Records	☐History and Physical	☐Operation Report(s)
☐Pathology Report	☐Consultation Report(s)	☐Discharge Summary
☐Progress Notes	☐Laboratory Report(s)	☐Radiology Report(s)
☐EKG Reports	☐Radiology Films	☐Alcohol or Drug Abuse Records
☐Physician's Orders	☐Other	

2. COVERING SERVICES BETWEEN ____________AND____________ (Insert either date(s) or "all")

IV. EXPIRATION & REVOCATION

A. THIS AUTHORIZATION WILL EXPIRE: (MUST CHOOSE ONE)

☐ 3 years after last office encounter ☐ Other (insert date or event): ______________________

B. RIGHT TO REVOKE

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. ACKNOWLEDGEMENTS

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I understand Norman Regional employed physicians/advance practice nurses/physician assistants are members of Oklahoma Physician Health Exchange (OPHX), and my provider may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.

6. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. SIGNATURE

This document must be signed by the individual or the individual's legal representative.

______________________________	______________________________
Signature (Patient or Legal Representative)	**Date**
______________________________	______________________________
Printed Patient or Legal Representative Name	**Capacity of Legal Representative (if applicable)**

Norman Regional Health System's Owned Clinics

Care for Women - Moore	Ortho Central
Care for Women - Norman	Primary Care – Blanchard
Diabetes & Nutrition Education	Primary Care – Doctor's Park
Endocrinology Associates	Primary Care – Robinson Medical Plaza
GI of Norman	Primary Care – NW Executive Park
Heart Plaza Imaging	Primary Care – Miles
Infectious Disease	Primary Care – Moore
Internal Medicine Doctors Park	Primary Care – Newcastle
Moore Pediatrics	Primary Care – Noble
Neurology Associates	Primary Care – NW Norman
Norman Heart & Vascular	Primary Care – South OKC
Norman Regional Oncology	Primary Care – Waterview
NRHS Journey Clinic	Primary Care – West Moore
NRHS Nephrology Associates	Primary Care – West Norman
NRHS Neurosurgery Associates	Pulmonary Clinic – Doctors Park
NRHS Surgical Associates	Pulmonary Clinic – Medical Plaza
Oklahoma Sleep Associates	Rheumatology Associates

Norman Regional Health System
ATTN: HIM Department
901 N. Porter Avenue, Norman, OK 73071

Name: ____________________

DOB: ________

CLINIC PATIENT PORTAL
ENROLLMENT GUIDE

Norman Regional Health System and our partner physicians and clinics are dedicated to helping you manage and control your health. One way we're helping you stay in charge of your health is with our Patient Portal.

The Patient Portal facilitates better communication with your physician's office by providing convenient, 24 hours a day, seven days a week access from the comfort and privacy of your home or office. You can use the patient portal to:

- Communicate with a nurse
- View your Personal Health Records
- Review your lab results and statements
- Request an appointment and see the date and time of an upcoming appointment
- Request a prescription refill

The Patient Portal is also completely secure and private. At your next visit to our office or clinic, at your request, a nurse or office staff member will provide you with a user name and password for the Patient Portal. Your decision to use the Patient Portal is completely up to you, but we hope you find this way to communicate with your physician's helpful.

Please remember, the Patient Portal should be used for non-urgent communication only. If you have a serious, pressing issue please call your physician's office. If you are experiencing a medical emergency, please call 9-1-1.

Steps to gain access to the portal

All new users via computer or laptop internet browser:

1. Once your Patient Portal is activated by your doctor's office, you will receive am email from Norman Regional Clinics. The email will contain your **Patient Portal Username**, **Password** and the **Patient Portal URL** link to the website named: https://health.healow.com/nrhs .
2. Click the link in the email to launch the Patient Portal.
3. Enter the **Username** and **Password** provided to you in the email. Click Login.
4. The User Validation Screen will display. Enter your **Date of Birth** OR **Phone Number**. Click Submit.
5. You will be required to enter a New Password and select a Security Question. When complete, click confirm.
6. The next window requires you to provide consent. Read the eClinicalWorks **consent form**. Click Next.
7. **Check the box** "I have read the consent form and the above information". Click Submit.
8. A small window will ask you to confirm. Click OK.
9. The Patient Portal Screen will display.

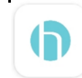
Name: ______________________

DOB: ____________

CLINIC PATIENT PORTAL
ENROLLMENT GUIDE CONTINUED

You can also download the Healow app for use on your smart phone/IPad or tablet (Optional):

1. After completing step 1 above, you can also gain access through our app.
2. Download the free Healow application from your app store. → → → →
3. Once installed, open the app and click get started.
4. In the practice code area, enter EICGAD.
5. It will open the login page for Norman Regional Clinics.
6. Enter the User name and Password that you created when you logged in on your computer.
7. Answer the association question (myself, spouse, etc.) and click login.
8. Accept the consent to use.
9. Set up a Pin Number of your choice to be used the next time you login in through the app.



healow
eClinicalWorks LLC

Returning users via computer or laptop using an internet browser:

1. To access from a web browser, simply type in: https://health.healow.com/nrhs and enter.
2. Or, you can access via the link in your welcome email above.
3. Enter your User name and Password and click submit.

Returning users via phone or tablet using the app:

1. Open your app.
2. Type your Pin Number created above.

An email from the Patient Portal will be sent to you any time new messages or updates to your medical record are posted to the portal. You **MUST then** log in to the portal to see the actual information; **NO** medical information will appear in the email.

If you forget your password and you are blocked from the portal, or you have questions about navigating the portal, please contact your doctor's office first. If they cannot resolve your issue, please contact NRH clinic support at portal@nrh-ok.com or call 405-307-7049.

To access records from a Norman Regional Health System hospital stay or ER visit, please contact NRHS hospital support at mynrhs_info@nrh-ok.com or call 405-515-6747. You will not be able to access hospital records from this patient portal.

☐ I wish to enroll for the Clinic Patient Portal. E-mail: ______________________

☐ I do not wish to be enrolled in Clinic Patient Portal.

Patient Signature: ______________________ Date: ______________

Name: ______________________________

DOB: ____________

NRHS Patient History

Preventive Health

Immunization	**Date Performed**	
Annual Lab (In the past year)		
Influenza Vaccination		
Prevnar (1st Pneumonia shot)		
Pneumovax(2nd Pneumonia shot)		
Tetanus Vaccination		
TDAP		
Zostavax (Shingles vaccine)		
Screening Test	**Date Performed**	**Results** (Normal/Abnormal)
Colonoscopy		
Mammogram		
PAP		
PSA (Prostate)		
Chest X-Ray		
Chest CT (Lung Scan)		
Dexa Scan (Bone Scan)		

Medications

See list provided ☐ **Do you have a medical marijuana card?** ☐Yes ☐No

If there is no attached list, please list all medications you are taking currently, including over the counter and herbal remedies. Please include dosage and number of times a day the medication is taken if known.

Medication Name:	**Dosage (mg, cc, etc.)**	**Frequency (how often)**

Pharmacy

____

Name: ______________________________
DOB: ____________

NRHS Patient History

Past Medical History

Please mark any current or previous illnesses or health problems.

___ Anxiety
___ Anemia
___ Arthritis
___ Asbestos Exposure
___ Asthma
___ Bipolar Disorder
___ Bleeding Disorder
___ Blood Clots
___ COPD/Emphysema
___ Chronic Pain related to ____________________
___ Dementia
___ Depression
___ Degenerative Joint Disease
___ Diabetes Mellitus
___ Heart Attack
___ Heart Disease
___ Heart Rhythm Problem
___ Hepatitis
___ High Cholesterol
___ High Blood Pressure
___ HIV
___ Kidney Disease
___ Lupus
___ Sleep Apnea
___ Parkinson's Disease
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Schizophrenia
___ Stroke
___ Thyroid Disease
___ Tuberculosis (positive PPD)
___ Ulcers

Other History/Details ____

____

____

Allergies

Please list all food and drug allergies:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Surgical History / Major Diagnostic Procedures

___ Appendectomy
___ Back Surgery
___ Bariatric (Weight Reduction)
___ Breast (was cancer involved____)
___ C-Section
___ Gall Bladder
___ Lung Biopsy
___ Lung Resection
___ Heart Catheterization
___ Heart Bypass Surgery
___ Prostate Surgery
___ Hysterectomy
____ (was cancer involved____)
___ Skin Cancer Removal (type __________________)
___ Tonsillectomy
___ Tubal Ligation
___ Tumor Removal
___ Vasectomy

Other History/Details ____

____

____

Hospitalizations

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Name: ______________________

DOB: ______________________

NRHS Patient History

Family History

Are you adopted? ___Yes ___No

	Father	Mother	Siblings	Paternal GF	Paternal GM	Maternal GF	Maternal GM
Living							
Deceased							
Diabetes							
Hypertension							
Heart Disease							
Mental Illness							
Cancer (type)							
Stroke							
Thyroid Disease							
High Cholesterol							
Asthma							
COPD/Emphysema							
Blood Clots							
Tuberculosis							
Headaches							
Seizure							
Other (specify)							
Unknown							

Social History

Tobacco Use:

___ Never smoked

___ Former smoker: How long has it been since you quit?
___ Less than 1 year ___ 1-5 years ___ 5-10 years ___ 10-20 years ___ 20+ years

___ Current smoker: If yes, how often do you smoke?
___ Daily ___ Frequently ___ Rarely
How soon after you wake up do you smoke?
___ Within 5 minutes ___ Within 30 minutes ___ Within 60 minutes ___ 60+ minutes
How many cigarettes do you smoke in 24 hours?
___ 5 or less ___ 6-10 ___ 11-20 ___ 21-30 ___ 31+
Do you use other forms of tobacco?
___ Cigar ___ Pipe ___ Chewing tobacco ___ Vapor
Are you interested in quitting?
___ Ready to quit ___ Thinking about quitting ___ Not ready to quit

Recreational Drug Use:

___ None ___ Marijuana ___ Cocaine ___ Heroin ___ Prescription Pain Pills ___ Methamphetamines ___ Other

Name: ______________________________

DOB: ________________

NRHS Patient History

Social History Continued

Alcohol Use:

Did you have a drink containing alcohol in the past year?

___No
___Yes: If yes, how often did you have a drink containing alcohol in the past year? ___Monthly or less ___2-4 times a month ___2-3 times a week ___4 or more times a week How many drinks did you have on a typical day when you were drinking in the past year? ___1-2 drinks ___3-4 drinks ___5-6 drinks ___7-9 drinks ___10+ drinks How often did you have 6 or more drinks on one occasion in the past year? ___Never ___Less than monthly ___Monthly ___Weekly ___Daily or almost daily

Caffeine:

___ Coffee ___ Soda ___ Energy drinks ___ Tea ___ Other ____________________ How many daily? _____

Children:

___ Yes ___ No If yes, how many? _______ What are their ages? ______________________

Exercise:

___ Daily ___ Occasionally ___ Rarely ___ Never

What kind of exercise? ______________________________

Marital Status:

___ Single ___ Married ___ Divorced ___ Widowed ___ Other

Do you have metal in your body? ___Yes ___No

Occupation:

____

Other:

Do you have a pacemaker? ___Yes ___No

Do you have a pain pump? Yes No

Are you claustrophobic? ___Yes ___No

Do you take daily aspirin? ___Yes ___No

Do you have metal in your body? ___Yes ___No

Pets:

___ Cats ___ Dogs ___ Birds ___ Horses ___ Other ______________________________

Travel Outside US:

___ Yes ___ No If yes, when? ______________________________

Social Assessment (Check all that apply)

___ Steady income ___ Receive support from the state ___ Live alone and need assistance to care for self

___ Homebound ___ Homeless ___ Unsafe home environment

___ Transportation barriers ___ Lack of financial or family support

In the last 12 months, how many times have you been:

_____ Hospitalized _____ In the ER _____ Seen in the doctor's office

NORMAN REGIONAL
Clinics

Name: ______________________

DOB: ______________

Review of Systems

CONSTITUTIONAL

Change in appetite		Yes		No
Fatigue		Yes		No
Fever		Yes		No
Sleep disturbance		Yes		No
Weight change		Yes		No

EYES

Blurring		Yes		No
Double vision		Yes		No
Itching		Yes		No

EAR/NOSE/THROAT

Hoarseness		Yes		No
Decreased hearing		Yes		No
Nosebleed		Yes		No
Ringing in ears		Yes		No
Sinus congestion		Yes		No
Sinus drainage		Yes		No
Sinus pain		Yes		No
Snoring		Yes		No

ENDOCRINOLOGY

Cold intolerance		Yes		No
Excessive sweating		Yes		No
Excessive thirst		Yes		No
Frequent urination		Yes		No
Heat intolerance		Yes		No

RESPIRATORY

Chest congestion		Yes		No
Cough		Yes		No
Hemoptysis		Yes		No
Shortness of breath		Yes		No
Wheezing		Yes		No

BREAST

Discharge from breast		Yes		No
Lump in breast		Yes		No
Pain in breast		Yes		No

CARDIOLOGY

Sleeps with multiple pillows		Yes		No
Chest pain		Yes		No
Claudication		Yes		No
Irregular heartbeat		Yes		No
Shortness of breath		Yes		No
Swelling in hands/feet		Yes		No

GASTROENTEROLOGY

Abdominal pain		Yes		No
Blood in stool		Yes		No
Constipation		Yes		No
Decreased appetite		Yes		No
Diarrhea		Yes		No
Difficulty swallowing		Yes		No
Heartburn/Reflux		Yes		No
Nausea		Yes		No
Vomiting		Yes		No

HEMATOLOGY/LYMPH

Bleeding problems		Yes		No
Easy bruising		Yes		No
Swollen glands		Yes		No

GENITOURINARY

Blood in urine		Yes		No
Frequent nighttime urination		Yes		No
Frequent urination		Yes		No
Loss of urine with cough/sneeze		Yes		No
Painful urination		Yes		No

MUSCULOSKELETAL

Joint stiffness		Yes		No
Muscle aches		Yes		No
Painful joints		Yes		No
Swollen joints		Yes		No
Muscle weakness		Yes		No

Name: ______________________________

DOB: ____________

Review of Systems

SKIN

Suspicious moles		Yes		No
Rash		Yes		No
Suspicious lesions		Yes		No

NEUROLOGY

Headache		Yes		No
Loss of strength		Yes		No
Memory loss		Yes		No
Seizures		Yes		No
Tingling/Numbness		Yes		No
Tremor		Yes		No
Vertigo		Yes		No

PSYCHIATRIC

Anxiety		Yes		No
Depressed mood		Yes		No
Difficulty sleeping		Yes		No
Stressors		Yes		No

NORMAN REGIONAL
Clinics

Name: ______________________________

DOB: ____________

Because depression can have a negative effect on your health we ask all adults to answer the following questions.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)	Not at all (0)	Several Days (1)	More than ½ the days (2)	Nearly every day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				