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 _____

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

NORMAN REGIONAL Clinics

Name: _____

DOB: _____

CONSENT AND AUTHORIZATION FOR MINOR

I, _____the undersigned hereby jointly and severally authorize the following persons, and each of them, to seek and obtain medical care for _____ ("the Minor"), as provided herein:

NAME	RELATIONSHIP	ADDRESS AND PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Each of the above named persons is authorized to seek care, diagnosis, and treatment of the minor as they may, in their discretion, deem appropriate and we hereby consent to such care, diagnosis, and treatment, it being our intention to give the broadest authorization to each of such persons in seeking and obtaining medical care.

In giving this Consent and Authorization, we recognize and understand that in situations where the Minor requires immediate medical or hospital care, it may not be possible to contact us, and that in such situations, we will not be able to knowledgeably evaluate and chose among the available alternative treatment or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing any or all treatment. We agree to pay the costs of any medical care that is provided in reliance on this Consent and Authorization.

Medical care, diagnosis , and treatment, as used herein, is to be interpreted liberally and includes, without limitation, x-ray examination, medical, surgical, or dental diagnosis or treatment, anesthesia, laboratory services and hospital care to be rendered to the Minor under general or special supervision and upon the advice of a physician, surgeon, or dentist licensed under the laws of the State of Oklahoma and any medical care reasonably necessary to diagnose, treat, or cure an illness, injury, disease, virus, symptom, or ailment.

A photocopy of this executed document, when presented by any of the above named persons, may be considered to be utilized as an original.

This authorization is valid until such time as it is rescinded in writing.

The undersigned are the parents or legal guardians of the Minor. Dated this _____ day of _____, 20_____.

_____ _____

(Signature of Parent or Legal Guardian) (Signature of Parent or Legal Guardian)

Minor's Birth Date: _____

Minor's Allergies: _____

Minor's Physician: _____ Other Physician: _____

(Name, Address, Phone) (Name, Address, Phone)

Hospital Emergency Department Preferences (if circumstance allows): _____

Date of Minor's Last Tetanus Shot: _____

Any/All Medications Minor is Taking: _____

Minor's Medical History: _____

NORMAN REGIONAL Clinics

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.

NORMAN REGIONAL Clinics

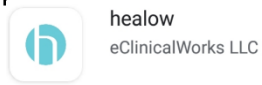
Name: _____

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.



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.

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: _____

NORMAN REGIONAL Clinics

Name: _____

DOB: _____

Pediatric Review of Systems

CARDIOLOGY

Murmurs		Yes		No
Cyanosis		Yes		No
Color changes of extremities		Yes		No

RESPIRATORY

Wheezing		Yes		No
Snoring		Yes		No
Persistent cough		Yes		No

HEMATOLOGY/LYMPH

Easy bruising		Yes		No
Anemia		Yes		No

CONSTITUTIONAL

Fever		Yes		No
Fatigue		Yes		No
Ill contacts		Yes		No

MUSCULOSKELETAL

Joint stiffness		Yes		No
Joint swelling		Yes		No
Fracture		Yes		No
Deformities		Yes		No

GASTROENTEROLOGY

Gassy		Yes		No
Spitting up		Yes		No

GASTROENTEROLOGY con't.

Vomiting		Yes		No
Constipation		Yes		No
Diarrhea		Yes		No
Change in bowel habits		Yes		No

DERMATOLOGY

Rash		Yes		No
Dry or sensitive skin		Yes		No
Acne		Yes		No
Itching		Yes		No
Hair loss		Yes		No

ENDOCRINOLOGY

Excessive thirst		Yes		No
Excessive urination		Yes		No

NEUROLOGY

Seizures		Yes		No
Gait abnormality		Yes		No
Incoordination		Yes		No
Fainting		Yes		No

OPHTHALMOLOGY

Drainage from eyes		Yes		No
Eye redness		Yes		No
Wears glasses/contact lenses		Yes		No

NORMAN REGIONAL Clinics

Name: _____

DOB: _____

Pediatric Initial History Questionnaire

Form Completed by:_____Relationship_____Date:_____

Household: Please list all those living in the child's home below

Name	Relationship	Age	Health problems

Does the child have any serious illnesses or conditions: _____
Does the child have any serious injuries: _____

Please list any surgeries and/or hospitalizations the patient has had and when:
Surgeries:_____
Hospitalizations:_____

Please list all medications (including strength) the patient is currently taking

_____ _____
_____ _____
_____ _____

Please list all allergies the patient has:

_____ _____
_____ _____

Birth History:

Birth weight:_____ Type of delivery:_____ Was the child early/late:_____
Initial Feeding:_____ Did baby go home with mother:_____ If not, why:_____
Was mother ill during pregnancy:_____ If yes, explain:_____
Did mother smoke while pregnant:_____ Use alcohol:_____ If yes, explain use:_____

Development:

Are you concerned about development	Yes	No	Explain:
Are you concerned about mental development	Yes	No	Explain:
Are you concerned about attention span	Yes	No	Explain:
Are you concerned about behavior at school	Yes	No	Explain:
Does the child have academic problems	Yes	No	Explain:
Is the child in special classes	Yes	No	Explain:

NORMAN REGIONAL Clinics

Name: _____

DOB: _____

Pediatric Initial History Questionnaire Continued

Social History:

If parents are separated or not living together, what is the child's custody status? _____

If parent lives outside the home, how often does the child see the parent? _____

Are there any conflicts	☐ Yes	☐ No
Does your child drink caffeine?	☐ Yes	☐ No
Do you have any pets?	☐ Yes	☐ No
Do you use a smoke detector in your home?	☐ Yes	☐ No
Is your child sexually active?	☐ Yes	☐ No
Does your child smoke?	☐ Yes	☐ No
Does your child drink alcohol?	☐ Yes	☐ No

What grade is your child in? _____

What school do they attend? _____

Family History: Have any of the child's family members had any of the following

Deafness	Yes	No	Comment:
Nasal allergies	Yes	No	Comment:
Asthma	Yes	No	Comment:
Tuberculosis	Yes	No	Comment:
Heart disease	Yes	No	Comment:
High blood pressure	Yes	No	Comment:
Anemia	Yes	No	Comment:
Bleeding disorder	Yes	No	Comment:
Liver disease	Yes	No	Comment:
Kidney disease	Yes	No	Comment:
Diabetes	Yes	No	Comment:
Bed wetting	Yes	No	Comment:
Epilepsy	Yes	No	Comment:
Alcohol abuse	Yes	No	Comment:
Drug abuse	Yes	No	Comment:
Mental illness	Yes	No	Comment:
Mental retardation	Yes	No	Comment:
HIV/AIDS	Yes	No	Comment:

Additional family history:_____

_____

Child's Past Medical History:

Chicken pox	Yes	No	When:
Frequent ear infection	Yes	No	When:
Ear/Hearing problems	Yes	No	When:
Nasal Allergies	Yes	No	When:
Eye/Vision problems	Yes	No	When:
Asthma or bronchitis	Yes	No	When:
Blood transfusion	Yes	No	When:
Frequent abdominal pain	Yes	No	When:
Constipation	Yes	No	When:

NORMAN REGIONAL Clinics

Name: _____

DOB: _____

Pediatric Initial History Questionnaire Continued

Child's Past Medical History Continued:

Bladder or kidney Infection	Yes	No	When:
Bed wetting after age 5	Yes	No	When:
Started menstrual period	Yes	No	When:
Problems with period	Yes	No	When:
Skin problems	Yes	No	When:
Frequent headaches	Yes	No	When:
Convulsion or Neurological problems	Yes	No	When:
Diabetes	Yes	No	When:
Thyroid or endocrine problems	Yes	No	When:
Use of drugs/alcohol	Yes	No	When:

Additional patient history:_____

_____