Rita M. Hancock, M.D.

Phone: 405-900-5300 • Fax: 405-900-6333

PLEASE PRINT

PATIENT INFORMATION

Date	Referring Physician	Referring Physician Phone

Last Name	Fist Name	Middle Initial	Sex ❑ M ❑ F
Address	City	State	Zip

Home Phone ( )	Age	Birthdate / /	Marital Status S M W D DEP	SS # — —

Employer/School	Address	City	State	Zip

Work Phone & Ext. ( )	Cell Phone	Email:

Patient's Nearest Relative (Other than Spouse)	Relation	Home Phone ( )	Work Phone & Ext. ( )

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient	Home Phone ( )

Address	City	State	Zip

Employer	SS # — —	Birthdate / /	Age	Work Phone & Ext. ( )

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance	Insurance Type: ❑ Group ❑ Individual ❑ Cobra

Address	City	State	Zip

Insured's Name on Card	I.D. #	Group #

Insured's Birthdate / /	Patient Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other	Insured's Sex: ❑ M ❑ F	Insured's SS # — —

Insured's Employer	Telephone & Ext. ( )

Secondary Insurance	Insurance Type: ❑ Group ❑ Individual ❑ Cobra

Address	City	State	Zip

Insured's Name on Card	I.D. #	Group #

Insured's Birthdate / /	Patient Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other	Insured's Sex: ❑ M ❑ F	Insured SSS # — —

Insured's Employer	Telephone & Ext. ( )

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Rita M. Hancock, M.D.. I understand I am financially responsible for any charge not covered by my insurance.

PATIENT OR AUTHORIZED PERSON ______________________ DATE ______________

RITA HANCOCK MD
2405 Westport Drive, Norman OK 73069

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NEW PATIENT PAPERWORK

NAME: _______________________________ AGE: _____ DOB: _____________ M / F DATE: ___________

OCCUPATION: ____ HEIGHT: _________ WEIGHT: ________

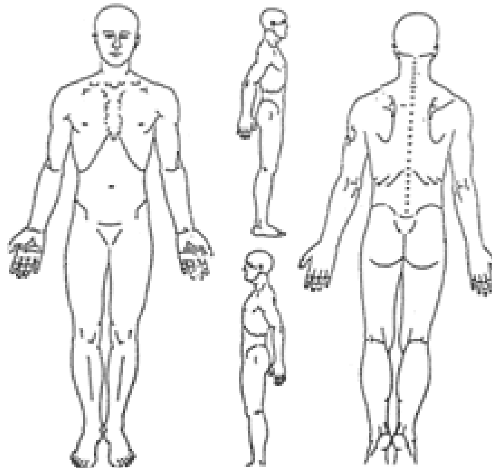
LANGUAGE: _______________________________ RACE/ETHNICITY: ___________________________________

REFERRED BY: _______________________________ FAMILY DOCTOR: _________________________________

WHAT PROBLEM ARE YOU HERE TO ADDRESS?____

WHAT IS THE CAUSE (IF KNOWN) e.g. fell, lifting injury, etc? ____

ON THE DIAGRAM BELOW, SHOW WHERE YOU HAVE SYMPTOMS; WRITE **"P"** FOR PAIN, **"N"** FOR NUMBNESS; **"T"** FOR TINGLING; **"B"** FOR BURNING; **"W"** FOR WEAKNESS; AND **"O"** FOR OTHER: (*EXPLAIN* WHAT "OTHER" MEANS). DRAW ARROWS/LINES/SHADING, AS NEEDED.



RATE YOUR PAIN *AT THIS MOMENT* (PICK *ONE* NUMBER ONLY; 1-10; with 10=WORST PAIN) _____

WHAT IS THE USUAL RANGE OF YOUR PAIN? (e.g. 3-7) ___________

ARE THE SYMPTOMS CONSTANT OR ON AND OFF? ______________FOR HOW LONG? _________________

NAME OTHER DOCTORS SEEN FOR THIS PROBLEM: ____

____

WHAT TREATMENTS HAVE HELPED? ____

WHAT TREATMENTS DID NOT HELP? ____

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PATIENT NAME: _____________________________ DATE OF BIRTH: ______________________

ANSWER #1-#7 IF YOU ARE HERE FOR A NECK/ARM/HAND PROBLEM (or EMG nerve test):

1. **PLEASE CIRCLE WHICH FINGERS ARE AFFECTED:**

   RIGHT: WHOLE HAND; THUMB; INDEX; LONG FINGER; RING FINGER; PINKY; N/A(NONE)

   LEFT: WHOLE HAND; THUMB; INDEX; LONG FINGER; RING FINGER; PINKY; N/A(NONE)

2. **CIRCLE THE *OTHER* UPPER BODY AREAS THAT BOTHER YOU:** NECK PAIN/STIFFNESS;

   KNOTS IN MUSCLES; SHOULDER PAIN (R OR L?); ELBOW (R OR L?) ; WRIST (R OR L); OTHER: _____

3. **DO THE SYMPTOMS SHOOT FROM YOUR NECK INTO YOUR ARM/HAND? Y / N**

4. **DO THE SYMPTOMS SHOOT FROM YOUR SHOULDER BLADE INTO THE ARM/HAND ? Y / N**

5. **CIRCLE IF SYMPTOMS ARE PRESENT WHEN:** DRIVING; SLEEPING; DOING HAIR/MAKEUP; CONSTANTLY

6. **CIRCLE IF YOU:** DROP THINGS; SHAKE OUT HANDS; TROUBLE OPENING JARS; DECREASED GRIP

7. **ARE THE SYMPTOMS WORSE WITH ACTIVITY AND BETTER WITH REST? Y / N**

ANSWER #8-#11 IF YOU ARE HERE FOR A BACK/HIP/LEG PROBLEM (or EMG nerve test):

8. **PLEASE CIRCLE WHAT PART OF THE FOOT IS INVOLVED**

   RIGHT: WHOLE FOOT; BIG TOE; TOP OF FOOT; BABY TOE SIDE; BOTTOM; HEEL; NONE OF FOOT

   LEFT: WHOLE FOOT; BIG TOE; TOP OF FOOT; BABY TOE SIDE; BOTTOM; HEEL; NONE OF FOOT

9. **DO YOU HAVE SYMPTOMS IN THE HIP, THIGH OR LOWER LEG? IF YES, WHERE? (indicate side and location, e.g. "left hip into outside part of thigh and lower leg, to the top of my foot): _________________________**

   ____

10. **CIRCLE WHAT MAKES YOUR SYMPTOMS WORSE:** SITTING; GOING FROM SIT TO STAND;

    STANDING; COUGH OR SNEEZE; STRAINING FOR A BOWEL MOVEMENT; OTHER: ___________________

11. **CIRCLE WHAT MAKES YOUR SYMPTOMS BETTER:** SITTING; STANDING; LAYING DOWN;

    LEANING FORWARD ON THE GROCERY CART WHILE WALKING; OTHER: __________________

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PATIENT NAME: ________________________________ **DATE OF BIRTH: _________________________**

IF THERE WAS AN INJURY THAT CAUSED THESE SYMPTOMS, WAS THE INJURY:

- A WORK-RELATED CASE ***THAT IS STILL OPEN*?** **Y / N**
- A MOTOR VEHICLE ACCIDENT CASE ***THAT IS STILL OPEN*?** **Y / N**
- OTHER PERSONAL INJURY CASE ***THAT IS STILL OPEN*?** **Y / N**
- ARE YOU REPRESENTED BY AN ATTORNEY FOR ANY OF THE ABOVE ? **Y / N**

IF YES, LIST THE ATTORNEY'S NAME AND CONTACT INFO __________________________________

EXPLAIN HOW YOU WERE INJURED: ____

CIRCLE THE OTHER SYMPTOMS THAT ACCOMPANY YOUR PROBLEM:

General: Fever, Weight Loss; Weight Gain, Night Sweats; Other: _________________
Eyes: Blurred Vision; Double Vision; Eye Pain: Dry Eyes; Other: _________________
Ears/Nose/Throat: Sinus Problems; Trouble Swallowing; Other: _________________
Heart: Chest Pain; Irregular Heartbeat; Heart Attacks; Other: _____________________
Lung: Trouble Breathing; Sputum Production; On Oxygen; Other: _________________
Bladder: Frequent Infections; Trouble Holding Urine; Other: ______________________
Bowel: Constipation; Diarrhea; Cramps; Bloating; Loss of Control; Other: _________
Muscle: Spasm; Twitching; Cramps; Weakness; Other: _________________________
Nerves: Numbness; Tingling; Pain; Weakness; Burning; Headaches; Memory Loss; Dizziness/Vertigo; Falling; Tremors; Other: ___________________________________
Skin/Extremities: Dry Skin; Swelling; Blueness of Fingers/Toes; Other: ___________
Psychological: Depression; Anxiety; Insomnia; Alcohol Abuse; Drug Abuse; Other: __
Hormones: Hair Loss; Cold Intolerance; Sweats; Nipple Discharge; Other: ___________
Immune System: Frequent Infections; Severe Allergies (Anaphylaxis); Other: ________

PAST MEDICAL HISTORY? (CIRCLE)

NO MEDICAL PROBLEMS	DEPRESSION	MIGRAINES	KIDNEY DISEASE	COPD/ASTHMA
HIGH BLOOD PRESSURE	ANXIETY	ARTHRITIS	KIDNEY STONES	SEIZURES
THYROID DISEASE	BIPOLAR	ANEMIA	LIVER DISEASE	STROKE
HEART ATTACK/HEART DISEASE	ALCOHOL ABUSE		DIABETES	OBESITY
HEART ARRHYTHMIA	OTHER CHEMICAL ADDICTION: ____________________________			
SPINE/JOINT PAIN	OTHER PSYCH DISORDER: ___________________________________			

CANCER (WHAT KIND? ____________________________________ (AND WHEN)? __________________
OTHER ILLNESS: ____
OTHER ILLNESS: ____

DRUG HISTORY (CIRCLE):

FORMER USE OF NARCOTICS; CURRENT USE; RECENTLY QUIT; *(PRESCRIPTION OR ILLEGAL?);*
CURRENTLY USE: COCAINE; HEROIN; IV DRUGS; MARIJUANA (RECREATIONAL OR MEDICAL)
OR: NEVER USED ILLEGAL DRUGS

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PATIENT NAME: ________________________________ DATE OF BIRTH: _____________________

PAST SURGICAL HISTORY? (CIRCLE)

NONE	HYSTERECTOMY	FRACTURE REPAIR: ______________________________
HERNIA	OPEN HEART/CABG	JOINT SCOPE/REPLACEMENT:______________________
PROSTATE	NECK OR BACK	OTHER: ____
TONSILS	CATARACTS	OTHER: ____
APPENDIX	GALLBLADDER	OTHER: ____

FAMILY HISTORY OF ILLNESS *(In the blank spaces, list family members who have these disorders (indicate WHICH family members, e.g. mother (M) , father (F), grandparents, sibling(s), etc.)*

HEART DISEASE_____________ HIGH BLOOD PRESSURE____________ STROKE: ____________
DIABETES______________THYROID___________________BLEEDING DISORDER_____________
MENTAL ILLNESS ______________________________________ ADDICTION__________________
SPINE/JOINT/NERVE PROBLEMS (WHAT KIND?)_______________IN WHOM? _______________
CANCER (TYPE?)_________________________ IN WHOM? ________________________________
CANCER (TYPE?)_________________________ IN WHOM? ________________________________
OTHER DISORDER (TYPE?) ________________IN WHOM? _________________________________

SOCIAL HISTORY:

SINGLE MARRIED WIDOWED DIVORCED
DO YOU DRINK ALCOHOL? Y / N IF YES, ________# DRINKS/WEEK, FOR _______YEARS.
DO YOU USE TOBACCO PRODUCTS? Y / N IF YES, ______# PACKS/DAY F0R ______ YEARS.

DRUG ALLERGIES?

NO KNOWN	MORPHINE	CODEINE	OTHERS (LIST): ____________________________
PENCILLIN	ERYTRHOMYCIN		____
LATEX	ADHESIVE TAPE		____
IODINE	SULFA		____

COULD YOU BE PREGNANT? Y/N (IF YES, NOTIFY THE DOCTOR DIRECTLY!)

IMAGING STUDIES: FOR TODAY'S PROBLEM, WHAT TESTS HAVE BEEN DONE?
(**CIRCLE** **):** X-RAYS CT SCAN MRI EMG BONE SCAN BONE DENSITY TESTING BLOOD-WORK OTHER____
AT WHAT FACILITIES? ____________________________________ WHEN? __________________

ORDERED BY WHICH PHYSICIAN? ____

WHAT MEDCINES DO YOU TAKE CURRENTLY (WITH DOSES AND FREQUENCY)?

____ ____
____ ____
____ ____
____ ____

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Acknowledgement of Receipt of Notice of Privacy Practice

I, ____________________________________ acknowledge that I have received a copy of the document
(Patient Name)

entitled "HIPAA Notice of Privacy Practices" from the office of Rita Hancock. This notice describes how the office of Rita Hancock MD may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ **Date:** ________________
(Signature of Patient or Patient Representative)

____
(Relation to Patient: Power of Attorney, Guardian, etc.)

Access to Medical Records

The person(s) listed below may have access to my medical records.

Name	Relation to Patient
____________________	____________________
____________________	____________________

____ **Date:** ________________
(Signature of Patient or Patient Representative)

____
(Relation to Patient: Power of Attorney, Guardian, etc.)

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PHARMACY INFORMATION

Please provide us with your preferred pharmacy information.

We refill ONLY prescriptions that we have on file for you.

*Pharmacy: ____

*Address: ____

*Phone: ____

All information above must be filled in. Otherwise, there may be a significant delay in completion of your refill request!

I ___________________________ understand that I can only use ONE pharmacy for prescriptions to be called in from this office.

Signature ____________________________Date: ________________

Rita Hancock MD Office Policies—Please Read Carefully

TO MOVE OR CANCEL YOUR APPOINTMENTS:

- If you "no-show" or cancel appointments without giving enough notice**, YOU** (*not your insurance company*) **will be charged $25 prior to your getting a second appointment.**
  - ***To change MONDAY appointments, call by 10am on the previous FRIDAY.***
  - ***To change Tues-Fri appointments, call at least 24 hours in advance.***
- You will not be given another appointment if you refuse to pay the $25.
- You may be discharged from the practice if you no-show or reschedule late a second time or if you refuse to pay the no-show or late cancellation fees.

YOU ARE RESPONSIBLE FOR PAYING YOUR BALANCE, *EVEN IF*:

- Your insurance/guarantor denies payment, pays partially, or refuses to pay for any reason.
- This includes **co-pays** due at the time of service and **co-insurance** fees and costs applied to your **deductible**. If you are not familiar with these terms or if you do not understand your coverage plan, please consult with your insurance company immediately.

WHERE ALLOWABLE, WE COLLECT A DEPOSIT ON YOUR PORTION OF THE BILL BEFORE SERVICES ARE RENDERED.

- A potential partial/full refund may be made after your claim is processed by insurance.

WHERE ALLOWABLE, WE CHARGE FOR ADDITIONAL SERVICES NOT REIMBURSED BY YOUR INSURANCE COMPANY:

- Because time is required for clerical activities not reimbursed by insurance companies, we charge for pre-authorizations ($25), medication refill requests *between visits* ($10), phone calls and/or referrals *that you request* from Dr. Hancock ($25), copying or sending medical records ($.50 printed/$.30 faxed), form completion ($10/page, up to $30), and interprofessional consultations ($18-$73, depending on time spent by the physician).

PLEASE GIVE US CORRECT INSURANCE & PHONE CONTACT INFORMATION & *NOTIFY US OF CHANGES IN THIS INFORMATION*!

- Claims can be denied and filing deadlines can be missed if case you fail to inform us about a change in your coverage or contact information. Ensuring that we have the correct information with which to file your claim is your responsibility.
- **WHAT PHONE NUMBER YOU ARE MOST LIKELY TO ANSWER?**

  ( ) ______________________________ **[Circle one: CELL / HOME / WORK]**
- **MAY WE EMAIL YOU IF YOU DON'T ANSWER YOUR PHONE CALLS?**
  If yes, what **EMAIL ADDRESS? (write legibly, please)**

  ____

IF YOU DO NOT HAVE INSURANCE, YOU ARE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE.

I affirm that I have read, understand, and agree to the above policies.

__________________________***(SIGNATURE)*** ***DOB:*** ____________

__________________________***(PRINTED NAME)*** __________________________***(DATE)***