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
1601 SW 89th ST, SUITE E-200; OKC, OK 73159
PHONE 405-900-5300
FAX 405-900-6333

NEW PATIENT PAPERWORK

NAME: _____ AGE: _____ DOB: _____ M / F DATE: _____

OCCUPATION: _____ HEIGHT: _____ WEIGHT: _____

LANGUAGE: _____ RACE/ETHNICITY: _____

REFERRED BY: _____ FAMILY DOCTOR: _____

INVOLVED REGION: WHAT BODY PARTS ARE BOTHERING YOU? (PLEASE CIRCLE)

HEAD or JAW; NECK; MID-BACK; LOW BACK; SHOULDER (R, L, Both); ELBOW (R, L, Both): WRISTS (R, L, Both); HANDS (R, L, Both); HIPS (R, L, Both); KNEES (R, L, Both); LOWER LEGS (R, L, Both); FEET (R, L, Both); OTHER BODY PART(S): _____

HOW DID THIS PROBLEM HAPPEN OR START?

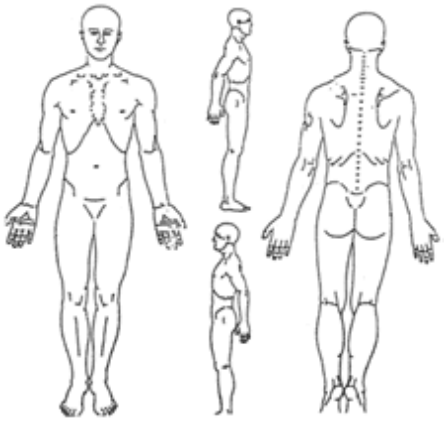
- ☐ NO OBVIOUS CAUSE;
- ☐ CAUSE IF KNOWN: _____
- ☐ AN ON-THE-JOB-INJURY CASE ***THAT IS STILL OPEN***
- ☐ A MOTOR VEHICLE ACCIDENT CASE ***THAT IS STILL OPEN***
- ☐ A PERSONAL INJURY CASE ***THAT IS STILL OPEN***

IF YOU ARE YOU REPRESENTED BY AN ATTORNEY FOR AN INJURY NOTED ABOVE, PLEASE LIST THE ATTORNEY'S NAME AND CONTACT INFO _____

DATE OF ONSET/INJURY:_____; OR: LENGTH OF TIME HAVING SYMPTOMS? _____

SYMPTOMS:

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



PAIN SCALE: ON A SCALE FROM 1-10 (10 = worst), PICK ONE NUMBER FOR YOUR PAIN NOW: _____

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PATIENT NAME: _____ DATE OF BIRTH: _____

AGGRAVATING FACTORS: CIRCLE WHAT MAKES YOUR PAIN WORSE.

☐ **NONE OF THE ITEMS BELOW APPLY. THE SYMPTOMS ARE CONSTANT**:

OTHERWISE, THESE MAKE MY SYMPTOMS WORSE: DRIVING; SLEEPING; DOING HAIR/MAKEUP; BENDING ELBOWS; SITTING; BENDING FORWARD; TWISTING; COUGHING; SNEEZING; STRAINING FOR A BOWEL MOVEMENT; GOING FROM SIT TO STAND; STANDING; WALKING; WORSE WITH ACTIVITY & BETTER WITH REST; OTHER: _____

PREVIOUS DIAGNOSTIC TESTS: 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? _____

PAST TREATMENT:

- **WHAT DOCTORS HAVE YOU SEEN? _____**
- **CIRCLE THE TREATMENTS YOU TRIED AND THAT *HELPED*:** LIMITING ACTIVITY; HEAT; ICE; INJECTIONS; ORAL MEDS; PHYS. THERAPY OR CHIROPRACTIC; REST; SURGERY; OTHER_____
- **CIRCLE THE TREATMENTS THAT YOU TRIED THAT *FAILED TO HELP*:** LIMITING ACTIVITY; HEAT; ICE; INJECTIONS; ORAL MEDS; PHYS THERAPY; CHIRO; REST; SURGERY; OTHER:_____
- **TOTAL NUMBER OF PHYSICAL THERAPY *PLUS* CHIROPRACTIC VISITS IN THE PAST 12 MOS? _____**

REVIEW OF SYSTEMS: 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: _____

☐ **NONE OF THE ABOVE SYMPTOMS APPLY TO ME**

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PATIENT NAME: _____ **DATE OF BIRTH: _____**

HISTORY OF DRUG ALLERGIES: (CIRCLE)

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

PAST MEDICAL HISTORY: (CIRCLE)

NO KNOWN MEDICAL PROBLEMS / OBESITY / HIGH BLOOD PRESSURE / HEART ATTACK / ARRHYTHMIA

DISEASE OF THE LIVER / DISEASE OF KIDNEY / COPD / ASTHMA / HEADACHE / SEIZURES / STROKE / MS

PARKINSON'S / FIBROMYALGIA / RHEUMATOID / LUPUS / ANK SPOND / DIABETES / HYPOTHYROID

DEPRESSION / ANXIETY / BIPOLAR / ALCOHOLIC / OTHER SUBSTANCE ABUSE / CANCER: _____

OTHER: _____

OTHER: _____

SOCIAL HISTORY:

(CIRCLE) 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.

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? _____

PAST SURGICAL HISTORY: (CIRCLE)

NONE	HYSTERECTOMY	NECK SURGERY: _____
HERNIA	OPEN HEART/CABG	LOW BACK SURGERY: _____
PROSTATE	GALLBLADDER	OTHER: _____
TONSILS	FRACTURE REPAIR	OTHER: _____
APPENDIX	JOINT SCOPE/REPLACEMENT	OTHER: _____

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PATIENT NAME: _____ **DATE OF BIRTH: _____**

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

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

CONTROLLED SUBSTANCE DRUG HISTORY (NARCOTICS, ETC.): (CIRCLE)

NEVER USED; PAST LEGAL USE (AFTER SURGERY, etc.); CURRENT LEGAL USE; MEDICAL MARIJUANA:
CURRENT ABUSE or PAST ABUSE OF: COCAINE; HEROIN; METHAMPHETAMINE; OTHER: _____

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

CONTINUED….

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PATIENT NAME: _____ DATE OF BIRTH: _____

RAPID HEALTH SCREEN

If you have <u>significant</u> HEADACHES, check the box that applies to you.

- ☐ WORSENING OVER TIME IN INTENSITY OR FREQUENCY (this will require a brain scan if not recently done)
- ☐ Currently the WORST HEADACHE OF YOUR LIFE (we will send you to the emergency room right now in this case).

Check the box or boxes that apply to you:

- ☐ PREGNANT.
- ☐ ON BLOOD THINNERS
- ☐ BLOOD CLOT in the limbs (what date and which limb?)_____
- ☐ ALLERGY to LOCAL ANESTHETIC, STEROIDS, or IODINE (Circle which!)
- ☐ SEIZURES
- ☐ IRREGULAR HEARTBEAT (ARRYTHMIA)
- ☐ CANCER (of what body part?) _____ (when diagnosed?)_____
- ☐ BRITTLE OR THIN BONES (osteoporosis or osteopenia)
- ☐ <u>Currently</u> broken bone, not yet healed (Which bone? _____)
- ☐ Recent surgery (What body part?)_____
- ☐ Rheumatoid arthritis involving the upper neck.
- ☐ STROKE, TIAs, ANEURYSMS (Circle which!)
- ☐ An INFECTION or OPEN WOUND. If so, where? _____
- ☐ FEVERS and/or night sweats *without obvious cause* (menopause doesn't count)
- ☐ Low back pain with new-onset LOSS OF CONTROL OF BLADDER **<u>AND</u>** BOWELS and/or NUMBNESS IN THE "PRIVATE REGION"
- ☐ Worsening night-time pain (where?)_____
- ☐ Progressively worsening weakness (where?)_____
- ☐ Unexplained weight loss

☐ **NONE OF THE ABOVE PROBLEMS APPLY TO ME**

_____

If there is a change in my status regarding these symptoms or diagnoses, I will inform Dr. Hancock prior to further treatment with her.

Signature: _____ Date: _____

PRINTED NAME: _____ Date of birth: _____

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PATIENT NAME: _____ DATE OF BIRTH: _____

IF YOU ARE HERE FOR A SPECIALIZED EMG (NERVE) TEST, PLEASE ANSWER THESE QUESTIONS:

ANSWER #1-#7 IF YOU ARE HERE FOR A NECK/ARM/HAND "EMG" NERVE TEST:

- **PLEASE CIRCLE WHICH FINGERS ARE AFFECTED:**
  RIGHT: THUMB; INDEX; LONG FINGER; RING FINGER; PINKY; WHOLE HAND; N/A(NONE)

  LEFT: THUMB; INDEX; LONG FINGER; RING FINGER; PINKY; WHOLE HAND; N/A(NONE)
- **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: _____
- **DO THE SYMPTOMS SHOOT FROM YOUR NECK INTO YOUR ARM/HAND? Y / N**
- **DO THE SYMPTOMS SHOOT FROM YOUR SHOULDER BLADE INTO THE ARM/HAND ? Y / N**
- **CIRCLE IF SYMPTOMS ARE PRESENT WHEN:** DRIVING; SLEEPING; DOING HAIR/MAKEUP; CONSTANTLY
- **CIRCLE IF YOU:** DROP THINGS; SHAKE OUT HANDS; TROUBLE OPENING JARS; DECREASED GRIP
- **ARE THE SYMPTOMS WORSE WITH ACTIVITY AND BETTER WITH REST? Y / N**

ANSWER #8-#11 IF YOU ARE HERE FOR A BACK/HIP/LEG "EMG" NERVE TEST:

- **PLEASE CIRCLE WHAT PART OF THE FOOT IS INVOLVED**
  RIGHT: BIG TOE; TOP OF FOOT; BABY TOE SIDE; BOTTOM; HEEL; WHOLE FOOT; NONE OF FOOT

  LEFT: BIG TOE; TOP OF FOOT; BABY TOE SIDE; BOTTOM; HEEL; WHOLE FOOT; NONE OF FOOT
- **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): _____**

  _____
- **CIRCLE WHAT MAKES YOUR SYMPTOMS WORSE:** SITTING; GOING FROM SIT TO STAND; STANDING; COUGH OR SNEEZE; STRAINING FOR A BOWEL MOVEMENT; OTHER: _____
- **CIRCLE WHAT MAKES YOUR SYMPTOMS BETTER:** SITTING; STANDING; LAYING DOWN; LEANING FORWARD ON THE GROCERY CART WHILE WALKING; OTHER: _____

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
_____	_____
Name	Relation to Patient

_____ **Date: _____**
(Signature of Patient or Patient Representative)

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

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

MASKS ARE REQUIRED AND THIS POLICY IS STRICTLY ENFORCED.

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 only 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, please consult with your insurance company.

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

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

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

- Because a substantial amount of time is required for clerical activities that are 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 (pending her approval, $25), copying or sending medical records ($.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 IN CASE OF A CHANGE 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, and payment responsibility falls back on you in that case.
- **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, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

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

_____***(SIGNATURE)*** ***DOB:*** _____

_____***(PRINTED NAME)*** _____***(DATE)***