DURANT FAMILY MEDICINE CLINIC HEALTH QUESTIONNAIRE

Name: Date: Birthday: Chart #

Reason For Visit

HAVE YOU BEEN OUT OF THE UNITED STATES ___**No** ____ **Yes-Date**_____**Where**_____

Medical History ***Mark "C" for current problems, check and indicate date when you had any of the following symptoms or diseases.***

	ADHD	Alcohol drinks per week
	ALLERGIC RHINITIS	Tobacco cig/day #years
	ANEMIA	year quit
	ANXIETY	Second Hand Smoke Exposure No Yes
	ARTHRITIS	Caffeine (Coffee /Tea/Soda) Cups per day
	ASTHMA	Illicit Drugs No Yes - Please list
	BACK PAIN CHRONIC LOW	**MEDICAL MARIJUANA CARD _____NO _____YES**
	BOWEL CHANGES/CONSTIPATION/DIARRHEA	Do you exercise regularly ____No ____Yes
	CANCER - what kind?	Sexually Active No Yes
	COPD	**FEMALES - PLEASE COMPLETE THE FOLLOWING:**
	DEPRESSION	Pain / Bleeding during or after sex No Yes
	DIABETES	Menstrual Flow:
	DIVERTICULOSIS	Regular Irregular Painful Cramps
	GERD	Days of Flow Length of Cycle
	HEART PROBLEMS:]	Date - 1st day last period
	HEPATITIS	Number of: Pregnancies Live Births
	HIGH BLOOD PRESSURE	Miscarriages Abortions
	HIGH CHOLESTEROL	Birth Control method
	HYPOTHYROIDISM	Birth Control pill name
	OBESITY	Hot Flashes NO YES
	SEIZURE	Date of last PAP test
	DIFFICULTY WITH URINATION	Normal Abnormal
	COVID-19 **DATE:**	Date of last Mammogram
	OTHER:	Normal Abnormal

Hospital Admissions Not Including Pregnancies	Year	HOSPITALIZATION	Year	SURGERY

Family History

FATHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other_____

Father - Year of Birth_____ [ ] Alive [ ] Deceased

MOTHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other_____

Mother - Year of Birth _____ [ ] Alive [ ] Deceased

SIGN HERE ->

RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DOCTOR SIGNATURE**

Name: **Date:** **Date of Birth:**

Medications prescribed by Doctors	Strength	How Often Do You Take This Medication
MEDICINE YOU TAKE NOT PRESCRIBED BY A DOCTOR	**STRENGTH**	**HOW OFTEN DO YOU TAKE THIS MEDICATION**
If you have a Medical Marijuana Card please describe how you use the marijuana (smoke, eat gummies, and how much you use each day)		
LIST ALL YOUR ALLERGIES		
COVID VACCINE YES NO	**DATE OF LAST VACCINE:**	

Patient_____

Alcohol Use Screening Audit C

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

____Yes
____ No

If Yes: How <u>often</u> did you have a drink containing alcohol in the past year?

_____ Never
_____ Monthly or less
_____ Two to four times in a month
_____Two to three times per week
_____Four or more times a week

If Yes: How <u>many</u> drinks did you have on a typical day when you were drinking in the past year?

_____ 1 or 2 _____ 3 or 4 _____ 5 or 6 _____7-9 _____10 or more

If Yes: How often did you have six or more drinks on one occasion in the past year?

_____Never _____Less than monthly _____Monthly _____Weekly _____Daily

Depression Screening PHQ2

Please indicate the answer that best describes you during the past two weeks:

Do you have little interest or pleasure in doing things?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Feeling down, depressed or hopeless?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Tobacco Control

___Non Smoker

___Chews Tobacco

___Former Smoker **YOU MAY STOP HERE IF YOU DO NOT CURRENTLY SMOKE.**

___Current Smoker ___everyday ___some days, but not every day

___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

After you wake up when do you smoke your first cigarette ___5 min ___6-30min ___31-60min ___after 60

Are you interested in quitting? ___Ready to quit ___Thinking about quitting ___Not ready to quit

Sexual History

Have you had sex in the last 12 months? (vaginal, oral or anal)? _____Yes _____No

With _____Men Only _____Women Only _____With Both Men & Women

Do you use protection? _____Yes _____No

Type of Birth Control: _____

Have you ever had an STD or STI? _____Yes _____No

Chlamydia? _____Yes _____No

Gonorrhea? _____Yes _____No

Syphilis? _____Yes _____No

Herpes? _____Yes _____No

Other? _____Yes _____No

DURANT FAMILY MEDICINE CLINIC

1600 W UNIVERSITY BLVD DURANT OK 74701 PHONE 580.924.5500 FAX 580.924.1991

DATE_____/_____/_____

PATIENT NAME_____
LAST FIRST MIDDLE (MAIDEN NAME IF MARRIED FEMALE)

Address_____City_____State_____Zip_____

Home Phone(_____) _____-_____Cell Phone(_____) _____-_____Work Phone(_____) _____-_____

DATE OF BIRTH_____/_____/_____ ☐MALE ☐FEMALE ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

SSN_____-_____-_____ **[ ]** Retired **[ ]** Disabled Occupation_____

Employer_____ Full Time Part Time Temporary

Employer Address_____City_____State_____Zip_____

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PLEASE CIRCLE ANSWERS FOR THE FOLLOWING INFORMATION: **Language**: English Espanol Other_____

Race: White Hispanic American Indian Asian Black Other:_____

Ethnicity: Choctaw Cherokee Hispanic Non-Hispanic Other:_____

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If patient is a minor, under 18 or student under 21, please provide the following Parental/Legal Guardian Information

Responsible Party/Legal Guardian_____SSN_____-_____-_____
LAST FIRST MIDDLE

Date of Birth_____/_____/_____Address ☐Same or _____City_____State___Zip_____

Relationship to Patient ☐Father ☐Mother ☐Legal Guardian ☐Other-describe_____

Home Phone(_____) _____-_____Cell Phone(_____) _____-_____Work Phone(_____) _____-_____

Employer_____Occupation_____

Employer Address_____City_____State_____Zip_____

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INSURANCE INFO – COMPLETE ONLY IF PATIENT IS NOT THE INSURED or IF MINOR IS COVERED BY PARENTS INSURANCE

Insurance Company_____ **☐Spouse ☐Parent ☐Other**
Relationship to Patient

Name of Insured_____ ____/_____/_____ _____-_____-_____
LAST FIRST Date of Birth Social Security Number

Does the Patient live with the Insured? **[ ]** Yes **[ ]** No **- If NO complete the following as it relates to the INSURED**

Home Phone(_____) _____-_____Cell Phone(_____) _____-_____Work Phone(_____) _____-_____

Address of Insured _____
Address/P O Box City State ZIP

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P**REFERRED PHARMACY – Please Circle One:** Corner Drug Durant Medical Supply & Pharmacy

Medical Center Pharmacy Medicine Store Pruett's Walgreens

Wal-Mart-Durant WalMart-Madill OTHER:_____

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Patient Name_____DOB___/__/____MR#_____

DFMC uses **automated calls/texts/emails** for appointments, lab results and general notifications like flu shot reminders, etc. Please tell us the preferred time and method you prefer for the following:

Preferred time to receive notification Morning Afternoon Evening

Preferred phone number for texts_____and/or voice mail_____

Email _____ [ ] No Email

Preferred Method of Contact

How should the staff or doctor contact you:

Contact me at **[ ]** Home Phone **[ ]** Cell Phone **[ ]** Work Phone

DFMC may **[ ]** leave a detailed message **[ ]** leave a call back number only

Other info_____

I authorize the following person(s) to obtain or provide information regarding my appointments, emergency contact, health and financial/insurance information: **PLEASE PROVIDE AT LEAST 2 CONTACTS.**

_____Relationship_____Phone_____

_____Relationship_____Phone_____

_____Relationship_____Phone_____

DFMC is unable to provide any information to anyone not listed above due to HIPAA Privacy Laws.

I have an Advance Directive regarding healthcare issues **[ ]** No **[ ]** Yes – Please provide a copy to DFMC

I have reviewed Durant Family Medicine Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document which is posted to the right of the check-in window. The information contained on this demographics form is true and correct. If this information changes I acknowledge it is my responsibility to update this information with Durant Family Medicine Clinic.

_____ _____/_____/_____

Signature of Patient /Legal Guardian if Patient is a Minor **Date**

DURANT FAMILY MEDICINE CLINIC
1600 W UNIVERSITY BLVD, DURANT OK 74701 580.924.5500 FAX 580.924.1991

Please take the time to fill out the forms we require. Filling these forms out carefully is very important, the information you provide us may affect your diagnosis, treatment, prognosis and the quality of the result we will achieve in treating your condition and/or obtaining payment from your insurance company. If any of the information contained on these forms changes in the future, please call us and notify us of the change.

PATIENT AGREEMENTS

ASSIGNMENT OF BENEFITS I hereby authorize and assign third party medical and/or liability benefits directly to DURANT FAMILY MEDICINE CLINIC for benefits due for services rendered. I understand that I am financially responsible for charges not covered by this authorization.

DATE____/____/____ **SIGNATURE**_____
Person Responsible for Payment

PAYMENT/DEFAULT I understand that payment is due at the time offices services are rendered. As a courtesy insurance claims will be filed on my behalf by DURANT FAMILY MEDICINE CLINIC. I agree to pay 100% of the patient responsibility upon receipt of billing and/or verbal notification of said balance by DURANT FAMILY MEDICINE CLINIC. In case of default of payment for medical services, I hereby agree to pay any and all collection fees. A billing fee may be charged to cover monthly statements, and I acknowledge that this is my sole responsibility.

PLEASE INITIAL_____

I acknowledge Insufficient (NSF) and Closed Account Checks Will Be Prosecuted To The Fullest Extent Of The Law. NSF Returned Checks are Subject to a Collection Fee Not To Exceed $100.00. Should a check be returned to this office by the bank unpaid, I agree that I am responsible for the check as well as the collection fee. If the check is collected at the bank I agree to pay the collection fee.

PLEASE INITIAL_____

MEDICARE PATIENT I agree to pay the Federally mandated Medicare copayment at the time service is rendered. Supplemental insurance claims will be filed by DURANT FAMILY MEDICINE CLINIC, however, deductibles and copayments are my responsibility.

PLEASE INITIAL_____

MANAGED CARE PATIENT I agree to pay my Managed Care Copayment – HMO & PPO – at the time services is rendered. I understand the referral process of my Plan and agree to abide by the prescribed rules.

PLEASE INITIAL_____

MINOR CHILDREN I understand that my minor child should always be accompanied by an adult who may authorize care. Payment for services rendered to minor children is the responsibility of the adult accompanying the child and I agree to make provisions for payment at the time services is rendered.

PLEASE INITIAL_____

RELEASE OF INFORMATION Information regarding treatment of a minor may only be released after signature of the legal guardian(s). I hereby authorize the release of any information necessary to process insurance claims for services rendered by DURANT FAMILY MEDICINE CLINIC. I hereby authorize DURANT FAMILY MEDICINE CLINIC to release any and all medical information to previous and future physicians involved in my care. If you email our office with a medical question or information you are giving implied consent for information to be transmitted electronically. Our office must have written permission to release information regarding your care to any other person, including but not limited to a spouse, parent, sibling, etc. A valid HIPAA authorization to release protected health information is required prior to release

PLEASE INITIAL_____

WORKER'S COMPENSATION I hereby authorize DURANT FAMILY MEDICINE CLINIC to deliver written reports, records, xrays or other information pertaining to my medical diagnoses or treatments to my employer and/or any attorney(s) or their representative(s) that I employ or in the future may employ relating to my Worker's Compensation injury.

PLEASE INITIAL_____

FORMS There is a $10 charge for each form completed by this office unrelated to your health insurance (ie disability, leave of absence, etc.) Forms and payment should be presented to the front office staff prior to your appointment. The Patient portion of the form must be completed and signed. A valid HIPAA authorization to release protected health information is required prior to release.

PLEASE INITIAL_____

I certify that the information given on the forms provided to me is correct and complete to the best of my knowledge and belief. Preceding information is agreed to by signature below

_____/_____/_____ **SIGNATURE**_____
DATE Person responsible for payment; under 18, parent or guardian must sign
PRINT NAME_____

Durant Family Medicine Clinic
1600 W. University Blvd
Durant, OK 74701
Phone 580.924.5500
Fax 580.924.1991

PAYMENT POLICY

Thank you for choosing DFMC as you primary care provider. We are committed to providing you with quality and affordable health care. This is our payment policy, please read it, ask us any questions you may have and sign in the space provided below. A copy will be provided to you upon request.

PRIVATE PAY. Payment is expected at the time of your visit.

INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. **Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage.** Non-covered services are those services you receive that may not be covered or not considered reasonable or necessary by your insurance. If your insurance changes, please notify us before your next visit so we can make the appropriate changes in our system.

CO-PAYMENTS/ COINSURANCE/ DEDUCTIBLES. All co-payments, co-insurance percentages, and/or non-covered service(s) and deductibles must be paid at the time of your visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients may be considered fraud.

FRAUD & PROOF OF INSURANCE. If you fail to provide us with the correct insurance information and we are unable to verify insurance coverage, you will be required to pay in full at the time of your visit or reschedule your appointment. *You are committing **FRAUD** if you do not give us all your insurance coverage information.*

CLAIMS SUBMISSION. We submit claims to all insurance companies and will assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

NON-PAYMENT. If your account is over 90 days past due, you will receive notice stating that you have 20 days to pay your account in full. Failure to pay your bill may mean that you will be discharged from this clinic. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our clinic will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS. All adult (21 yrs. old) patients who "no show" their appointment, without calling to cancel, may be charged $25.00 per missed visit. Please call the front office to cancel visit 24 hours prior to your appointment.

Durant Family Medicine Clinic's prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____
PATIENTS NAME, PRINTED SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR

_____
DATE

DURANT FAMILY MEDICINE CLINIC

MEDICAL HOME AGREEMENT

FOR ACCOUNT _____

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your PCP, to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of all medications-prescription, over-the-counter, herbal and street drugs. This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER

_____ _____

Patient or Guardian Signature Date

_____ _____

DFMC Staff Signature Date

Durant Family Medicine Clinic

1600 W University Blvd Durant OK 74701
Phone 580.924.5500 Fax 580.924.1991

MEDICATION CONTRACT

All medications prescribed by a Durant Family Medicine Clinic physician after the date of this contract are included herein and made a part of this Medication Contract.

1. I acknowledge and consent to treatment with non-narcotic, narcotic, opioid or controlled substances. I understand that these medications were prescribed to me because I state that I have a serious condition. I am aware of risks associated with these meds that may include drowsiness, constipation, slowing of reflexes. I know that I should not drive or participate in any activity requiring mental alertness or physical coordination when I take narcotic, opioid or controlled substance medication(s). Further, I know that the use of these medications can lead to tolerance, physical dependence or addiction.
2. I agree to take my medication(s) as prescribed and directed by my DFMC physician.
3. I acknowledge and understand that I will need regular appointments to continue this treatment. Prescriptions will only be refilled at the time of the appointment and never over the phone. I will call the office for an appointment one (1) week before I run out of my medication.
4. I acknowledge and understand that I cannot obtain these or similar medications from a source other than Durant Family Medicine Clinic. I acknowledge and understand that doing this will result in no further similar prescriptions given for this problem from Durant Family Medicine Clinic.
5. I acknowledge and understand that Durant Family Medicine Clinic will not refill medications that have been lost, stolen, misplaced or damaged.
6. I agree not to share, give or sell my medication to any other person and I am aware that this constitutes a criminal act.
7. I acknowledge and understand that I cannot use alcohol or any street drugs with my medication.
8. I acknowledge and understand that if I am receiving medication or am the parent of a child receiving medication, I agree to random drug screening at any time at my own expense, including today. If I am called for a random drug test I agree to present to the office within 3 hours for drug screening. Failure to appear and provide valid urine for testing with be considered a violation of this contract. I understand that if I fail to show up for a medical management appointment it is grounds for termination from DFMC.
9. I agree to release this contract information to Alliance Health Durant Hospital and to pharmacies in Bryan and surrounding counties.
10. I consent to all pharmacies communicating with Durant Family Medicine Clinic with regard to my use of controlled and non-controlled substances and the providers of those substances.
11. I understand that a state and/or nationwide database will be accessed to find all medications I have been prescribed by all medical providers.
12. I understand that I must request a refill for all non-narcotic routine medications five (5) days before I will be out of the medication by calling my pharmacy. Routine medications for chronic disease(s) require an office visit every 3-6 months and may not be refilled if I do not see my physician on a routine basis.
13. I acknowledge and understand that violation of this contract is grounds for termination from Durant Family Medicine Clinic.
14. If I violate any tenet of this contract, I acknowledge and understand that this contract is broken and my medication will no longer be prescribed.

Print Name of Patient_____

_____ _____/_____/_____

Signature of Patient or Parent/Legal Guardian if under 18 **Date**