Martha Robinson, M.D.

114 N. Grand, #508
Okmulgee, OK 74447

Appt. Date _____
Appt. Time _____

PATIENT INFORMATION

Patient Name: Last	First	MI	Date:
Mailing Address:	City	State	Zip
Date of Birth:	Social Security #:		
Marital Status: □ S □ M □ D □ W	Sex: □ Male □ Female	Student: □ Yes □ No	
Home Phone: **(Circle preferred phone #)**	Cell Phone:		
Email:			
Employer:	Employer Phone:		
Employer Address:	City	State	Zip

RACE

□ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other

INSURANCE CARD HOLDER: □ Self □ Spouse □ Parent

Card Holder's Name: Last	First	Middle	
Mailing Address:	City	State	Zip
Date of Birth:	Social Security #:		
Home Phone:	Cell Phone:		
Employer:	Employer Phone:		
Employer Address:	City	State	Zip

LEGAL GUARDIAN OR POWER OF ATTORNEY

Name:	Relationship:		
Mailing Address:	City	State	Zip
Home Phone:	Cell Phone:		
Employer:	Employer Phone:		

PHARMACY

Pharmacy Name:	City:	Phone:

EMERGENCY CONTACT

Name:	Relationship:	
Home Phone:	Work Phone:	Cell Phone:

SIGNATURES REQUIRED FOR

1) **Patient Authorization for Treatment and Release of Information & Financial Policy**
2) **HIPPA Regulations**
3) **Financial Policy**

- All copayments and surgical deductibles are due at the time of service, without exception.
- Please keep in mind that many insurance plans have different deductibles and copays for office visits – separate from surgical services (biopsies, mole removal, liquid nitrogen – "freezing"-, tag removal, etc. Therefore, you may have a copay and deductible for the office visit AND another deductible for any surgical procedure. We are unable to always inform you of what services are covered or not covered.
- You must present your CURRENT insurance card at each visit so we file the claim correctly. We are not responsible for refiling claims because of outdated or incorrect cards. We file participating plans as a courtesy to you.
- Statements are only sent to you once we have heard from the insurance company and you have a remaining balance. If we do not receive payment in full from you within 60 days, the account is turned over to our collection agency. Interest charges may apply.
- SELF PAY: Payment in full due at the time of service. We do not have a payment plan.
- I understand the above financial policy and agree to abide by it.

Signed _____ **Date** _____

PATIENT AUTHORIZTION FOR TREAMENT AND RELEASE OF INFORMATION:

By my signature, I authorize the practice of Martha Robinson MD (MMR) to provide general healthcare services to me; release any of my medical records or other personal/medical information for purposes of determining benefits for services, obtaining reimbursement from my insurance co., or any public agency or third-party payor necessary. I also authorize MMR, including any lab or diagnostic test facility performing services on my behalf, to release any of medical records or personal/medical information to other physicians, labs, or diagnostic facilities involved in my care or treatment for purposes of billing, developing an appropriate treatment plan/diagnosis, quality assurance, utilization review or other analysis designed to monitor and maintain quality of care. **IN AUTHORIZING THIS RELEASE OF INFORMATION, I UNDERSTAND THAT SUCH INFORMATION MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND AIDS.**

ASSIGNMENT OF BENEFITS: By signing below, I hereby authorize payment of any benefits for services rendered by MMR to be made directly to MMR and authorize MMR to refund any overpaid insurance benefits where the overpayment is subject to coordination of benefits.

SIGNATURE: By signing below, patient represents that patient is 18 years of age or over and legally capable to give consent to treatment and to authorize release of the above information and to agree to all financial policies of MMR. By signature of parent or legal guardian, such individual represents that patient is under age 18 (a minor) or has a court-appointed guardian and agrees to all above policies. I have read and understand and agree to all of the above information.

PATIENT/parent or legal guardian signature	**Relationship to patient**	**Date**

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Martha Robinson, MD, PC

I am a patient or the parent of a patient or legal guardian of a patient of Martha Robinson, MD. I hereby acknowledge receipt of the doctor's Notice of Privacy Practices.

Name of Patient (please print): _____ **Relationship to Patient:** □ **Self** □ **Parent** □ **Legal Guardian**

Signature: _____ **Date:** _____

Past Medical History

Atrial fibrillation	Breast Cancer	Anxiety	Seizures	Bone Marrow Transplantation
Hypertension	Colon Cancer	Arthritis	Hepatitis	Coronary Artery Disease
Prostate Cancer	HIV/AIDS	BPH	Lymphoma	Hypercholesterolemia
Hyperthyroidism	Pacemaker	GERD	Diabetes	End Stage Renal Disease
Hypothyroidism	Depression	Stroke	Leukemia	Valve Replacement
Radiation Treatment	Lung Cancer	COPD	Hearing Loss	**NONE**

Other_____

Past Surgical History

Bladder Removed	Appendix Removed	Mastectomy (Right, Left, Bilateral)
Gallbladder Removed	Breast Reduction	Lumpectomy (Right, Left, Bilateral)
Coronary Artery Bypass	Breast Implants	Breast Biopsy (Right, Left, Bilateral)
Mechanical Valve Replacement	PTCA	Colectomy: Colon Cancer Resection/Diverticulitis/IBD
Biological Valve Replacement	Heart Transplant	Joint Replacement-Knee (Right, Left, Bilateral)
Kidney Removed (Right, Left)	Kidney Biopsy	Joint Replacement-Hip (Right, Left, Bilateral)
Kidney Stone Removal	Kidney Transplant	Ovaries Removed: Endometriosis/Cyst/Ovarian Cancer
Prostate Removed: Prostate Cancer	Spleen Removed	Testicles Removed (Right, Left, Bilateral)
Prostate Biopsy	Skin Biopsy	Hysterectomy: Fibroids/Uterine Cancer
TURP	**NONE**	

Other_____

Skin Disease History

Blistering Sunburns	Dry Skin	Acne	Poison Ivy	Squamous Cell Skin Cancer
Flaking or Itchy Scalp	Eczema	Asthma	Actinic Keratosis	Precancerous Mole
Basal Cell Skin Cancer	Melanoma	Psoriasis	Hay Fever/Allergies	**NONE**

Other_____

Do you wear sunscreen? Yes____ No____ If yes, what SPF?_____

Do you tan in a tanning salon? Yes_____ No____

Do you have a family history of Melanoma? Yes____ No____ If yes, which relative(s)?_____

Allergies

_____ _____ _____

_____ _____ _____

Social History

Currently smokes? Yes____ No____ Has smoked in the past? Yes____ No____

Drug use? Yes____ No____

Other_____

Martha M Robinson, M.D.

Do you have any of the following?

Artificial joints within past two years?	Yes____	No____
Pregnancy or planning a pregnancy?	Yes____	No____
Problems with bleeding?	Yes____	No____
Problems with scarring (hypertrophic or keloid)?	Yes____	No____
Blood thinners?	Yes____	No____
GI upset with antibiotics?	Yes____	No____
Yeast infections with antibiotics?	Yes____	No____
Problems with healing?	Yes____	No____
Rapid heartbeat with epinephrine?	Yes____	No____
Immunosuppression?	Yes____	No____

Are you currently experiencing any of the following?

Changing mole?	Yes____	No____	Hay fever?	Yes____	No____
Rash?	Yes____	No____	Joint aches?	Yes____	No____
Abdominal pain?	Yes____	No____	Muscle weakness?	Yes____	No____
Anxiety?	Yes____	No____	Neck stiffness?	Yes____	No____
Bloody stool?	Yes____	No____	Night sweats?	Yes____	No____
Bloody urine?	Yes____	No____	Seizures?	Yes____	No____
Blurry vision?	Yes____	No____	Shortness of breath?	Yes____	No____
Chest pain?	Yes____	No____	Sore throat?	Yes____	No____
Cough?	Yes____	No____	Thyroid problems?	Yes____	No____
Depression?	Yes____	No____	Unintentional weight loss?	Yes____	No____
Fever or chills?	Yes____	No____	Wheezing?	Yes____	No____
Headaches?	Yes____	No____			

Do you have any of the following?

Allergy to lidocaine?	Yes____	No____	Allergy to adhesive?	Yes____	No____
Pacemaker?	Yes____	No____	Allergy to topical antibiotic ointments?	Yes____	No____
Defibrillator?	Yes____	No____	Premedication prior to procedures?	Yes____	No____
Artificial heart valve?	Yes____	No____			

Martha M Robinson, M.D.

Primary Care Doctor

Doctor: _____ **Phone:** _____ **Fax:** _____

Address: _____

Vaccine History

TB test: Date_____ Results: (positive or negative) **Influenza Vaccine given?** Date_____

Pneumococcal Vaccine given? Date_____ **Shingles Vaccine given?** Date_____

Alcohol Usage

 # alcoholic drinks: none_____ <1/day_____1-2/day_____3 or more/day_____

Nicotine Usage

Currently smoke? Yes___ No___ **Smoked in the past?** Yes___ No___

Ebola Risk

Traveled to West Africa? No___ Yes/when? _____ **Contact w/ Ebola patient?** No____ Yes/when? _____

Fever > or = 100.4 degrees? No___ Yes___; if yes, headache/weakness, muscle pain, vomiting, diarrhea, abdominal pain and/or hemorrhage?

Medications

For age 18 and under: Height_____ Weight_____

Please list ALL MEDICATIONS (including over the counter medications):

NAME OF MEDICATION	DOSAGE	TAKEN HOW OFTEN

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