OASIS MEDSPA

2300 36th Ave NW Norman, OK 73072
405-579-7664

Name_____Date_____

Address_____City_____Zip_____Zip Plus_____

Home Phone_____Cell Phone_____Social Security #_____

Date of Birth_____Age_____Male_____Female_____Martial Status_____

Referred By_____Personal Physician_____

Patient's Employer_____Position_____

Employers Address_____City_____Zip_____

Spouse's Name_____Spouse's Employer_____Spouse's DOB_____

PERSON RESPONSIBLE FOR BILL

Name_____ Date of Birth_____ Relationship_____

Address_____City_____State_____Zip_____

Employer_____Address_____Phone_____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

Name_____Address_____Telephone_____

IN ORDER TO CONTROL OUR BILLING COSTS AND REDUCE FEE INCREASES, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME OF SERVICE.

AUTHORIZATIONS

Benefits to Physician:
I hereby authorize payments directly to the physician of the surgical and/or medical benefits. I also understand that I am
responsible for any portion of my bill not covered by my insurance company.

Release of Information:
I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES.
The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Date_____20_____ Signed_____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OR HAVE BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF THE HIPPA NOTICE OF PRIVACY PRACTICES.

Date_____20____ Signed_____

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Review of Systems

Do you currently have any of the following problems?	Yes	No	If yes, please explain:
-Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
-Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	_____
-Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	_____
-Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
-Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
-Urinary problems (eg. pain or discomfort, blood in urine)	☐	☐	_____
-Skin problems (e.g. rashes, excessive dryness)	☐	☐	_____
-Musculoskeletal problems (e.g. muscle aches, joint pain swollen joints)	☐	☐	_____
-Neurological problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	_____
-Psychiatric Problems (e.g. depression, anxiety)	☐	☐	_____
-Are you allergic to Latex products?	☐	☐	

Date of last Flu Shot_____

If UNDER 18 years of age, have the following immunizations been received:

DTaP, 4 shots Yes_____NO_____
Polio 3 shots Yes_____No_____
MMR 1 shot Yes_____No_____
HiB 2 shots Yes_____No_____
Hep B 3 shots Yes_____No_____
VZV 1 shot Yes_____No_____
PCV 4 shots Yes_____No_____
Hep A 2 shots Yes_____No_____
RV 2 shots Yes_____No_____
Flu 2 shots Yes_____No_____

Family and Social History

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration?) Yes No If yes please explain: _____

_____

Have you smoked in the last 24 months? ☐ Yes ☐ No If yes, how many packs per day_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____