**Skiatook Family Clinic**
201 E. 2nd St.
Skiatook, OK 74070
(918) 396-1262 Fax (918) 396-4598

May 5, 2021

Re: New Patient Application

Dear Prospective Patient,

Thank you for your interest in Skiatook Family Clinic. Since 2016, we have been a growing locally owned and operated Skiatook business. Our providers have over 25 years of combined experience caring for the needs of complex ambulatory primary care patients and are excited about their patients and practices. Our practice philosophy supports people with small-town values, and we understand the strain distance and traveling time can place on patients. So we do our best to be timely, treat patients in the community, and support the other local healthcare businesses.

We treat many health conditions, including high blood pressure, diabetes, cholesterol problems, obesity, mental health issues, and many other common ailments. All of our providers have taken additional training in addiction medicine and can provide medication-assisted treatment to patients with opioid use disorder when needed. And a licensed counselor is also available to see some patients on-site. However, we must refer patients off-site for imaging, women's health checkups, and specialty consultations such as orthopedics, surgery, and chronic pain management services.

On a case-by-case basis, we accept new patients age six and up. If you would like to join our health family, please complete the attached documents and return them to the office at your earliest convenience for consideration and scheduling your first appointment.

Sincerely,

Layne Subera DO

**** Electronic Signature Verified ****

| **Name:** | **Date of Birth:** | **Date:** |
|---|---|---|

Skiatook Family Clinic New Patient History Form

| **History of the Present Illness:** These questions help us understand your needs. |
|---|
| **Reason** for today's visit: |
| **Duration** of symptoms: |
| **Body Area** effected: |
| **Severity** of symptoms: Mild Moderate Severe |
| **When** do symptoms occur? |
| **What** helps or worsens symptoms? |
| **Associated** problems: |
| **Circumstance** when condition started: |

Drug allergies typically cause swelling, wheezing, shortness of breath or a rash.

| **Drug Allergies:** |
|---|

Please provide the name of your medications, the strengths and your daily dosing schedules.

| **Current Medications:** |
|---|
| |
| |

We provide counseling and prescription services for people with tobacco and opioid use disorder.

| **Tobacco use:** None _____ packs per day. Would you like a prescription to help quit? Yes No |
|---|
| **Alcohol use:** None _____ drinks per week. One drink = 4 oz. wine or 12 oz beer or 2 oz. spirits |

State Title 510 directs physicians to ask the following questions of pain patients.

| **Pain Level:** None 1 2 3 4 5 6 7 8 9 10 out of 10 (with 10 being the worst possible) |
|---|
| **Substance Abuse History:** Do you have a history of illegal or street drug use? Yes No |
| Describe: |

Please list **your** previous medical diagnosis and health problems in the space below.

| Tell us your **Past Medical History...** |
|---|
| |
| |

Please list health problems that tend to **run in your family** in the space below.

| Tell us your **Family's Medical History...** |
|---|
| |
| |

In the review space below, circle or write in any **current problems** that you may be experiencing.

| **Review of Systems** | |
|---|---|
| **Constitution** | Weight loss Weight gain Fever Chills Fatigue |
| **Ears—Throat** | Hearing Loss Congestion Sore throat Ear pain |
| **Stomach** | Heartburn Nausea Vomiting Diarrhea Constipation Blood in stool Dark stools |
| **Skin** | Rashes Moles Lumps Dryness Change in pigment |
| **Hormones** | Excess thirst Excess urination Cold/Heat intolerance Diabetes Irregular periods |
| **Urinary** | Blood in urine Nocturnal urination Frequency Burning Pregnancy |
| **Glands** | Anemia Easy bruising Easy bleeding Lymph node enlargement |
| **Eyes** | Double vision Mattering Itchiness Blurring Loss of vision |
| **Heart** | Chest pain or pressure Forceful beats Irregular beat Murmur High Blood Pressure |
| **Skeleton** | Joint pain Joint stiffness Joint Swelling Muscle aches Gout |
| **Nerves** | Dizziness Fainting Seizures Spinning sensations Weakness Tremors |
| **Allergies** | Medicine Allergy Dye Allergy Seasonal Allergy Food allergy Latex Allergy |
| **Lungs** | Dry cough Cough up blood Cough up mucus Wheezing Asthma |
| **Emotions** | Depression Insomnia Panic Anxiety Memory disturbance Suicidal thinking |

# Current Medication List

| Name: | Date of Birth: |
|---|---|

Please help us update your medical record by listing all of your medication allergies and all of the medications that you are currently using. Include all prescriptions from other doctors. List prescriptions first and over the counter products last if space remains.

| Medication Allergies | | | | |
|---|---|---|---|---|
| | | | | |

| No. | Drug Name | Dosage | Frequency | Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
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| 16 | | | | |
| 17 | | | | |
| 18 | | | | |
| 19 | | | | |
| 20 | | | | |

| Reviewed: | | | | | |
|---|---|---|---|---|---|
| | | | | | |

archive

5/7/21

# Skiatook Family Clinic

201 East Second, Skiatook, OK 74070

## ORT Risk Assessment

| Circle All That Apply | Yes | No |
|---|---|---|
| **Family history of substance abuse** | | |
| Alcohol | 1 | 0 |
| Illegal drugs | 1 | 0 |
| Rx drugs | 1 | 0 |
| **Personal history of substance abuse** | | |
| Alcohol | 1 | 0 |
| Illegal drugs | 1 | 0 |
| Rx drugs | 1 | 0 |
| Age between 16-45 years | 1 | 0 |
| **Psychological problems** | | |
| ADD, OCD, bipolar, schizophrenia | 1 | 0 |
| Depression | 1 | 0 |
| Total | | |

Adapted from ORT-R by Cheatle, M, Compton, P, Dhingra, L, Wasser, T, O'Brien, C. (2019)

# Skiatook Family Clinic

## PATIENT INFORMATION

NAME:_____
Last First Middle Nickname

ADDRESS:_____
P.O. Box/Street City State ZIP

EMPLOYER:_____EMPLOYER Phone_____

HOME PHONE:_____ CELL PHONE_____

SSN:_____BIRTHDATE_____ RACE:_____

LANGUAGE_____ ETHNICITY_____ MALE FEMALE

Who referred you to us?_____

Emergency contact OUTSIDE home:_____

## RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY:_____ SSN:_____

HOME PHONE:_____ CELL PHONE:_____

EMPLOYER:_____ PHONE:_____

## INSURANCE INFORMATION

PRIMARY INS:_____ SECONDARY INS:_____

ADDRESS:_____ ADDRESS:_____

CITY/STATE/ZIP:_____ CITY/STATE/ZIP:_____

POLICYHOLDER:_____ POLICYHOLDER:_____

BIRTHDATE:_____ BIRTHDATE:_____

SSN:_____ SSN:_____

GROUP/PLAN#_____GROUP PLAN#_____

SELF SPOUSE PARENT CHILD SELF SPOUSE PARENT CHILD

# Skiatook Family Clinic

201 East Second, Skiatook, OK 74070

## Authorization for Release of Medical Record Information

Patient Name: _____

Parent or Guardian (if minor): _____

I hereby authorize Skiatook Family Clinic to disclose health related information from my or my minor child's medical records to (name and address):

Name: _____

The specific information I wish to have released is: ___ Any and all.

_____

_____

_____

I understand I may revoke this consent at any time, except where information has already been released. This authorization expires on the date listed below.

Expires: _____ ____ Do not expire authorization

Signature[1]: _____ Date: _____

Witness: _____

[1] Parent or Legal Guardian if Minor.