The Oaks
Family Healthcare LLC

Kimberly F. Owens, M.D.
2298 E. University Dr., Suite A-301
Auburn, AL 36830

New Patient Intake Form

Today's Date: _____

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: _____ **BIRTHDATE** _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: *HOME* ( ) _____ *WORK*: ( ) _____ *CELL*: ( ) _____

EMAIL ADDRESS: _____

Sex: _____ Race: _____ Ethnicity: NOT Hispanic or Latino Social Security #: _____

Employer: _____ Occupation: _____

Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Retirement Date: _____

Your Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Birthdate: _____

Spouse's Social Security #: _____ Spouse's Cell Phone #: _____

Person To Contact In Case of Emergency: _____

Relationship To You: _____ Phone #: _____

Previous Primary Care Provider:

Billing Information

Primary Insurance:

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Relationship to Policy Holder: _____

Secondary Insurance:

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Relationship to Policy Holder: _____

LOCAL PHARMACY

NAME/ ADDRESS: _____

PHARMACY PHONE # ( ) _____ FAX # ( ) _____

MAIL ORDER PHARMACY

NAME/CITY/STATE: _____

PHARMACY PHONE # ( ) _____ FAX # ( ) _____

Medical History

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PLEASE CIRCLE ANY ILLNESSES YOU HAVE HAD:

☐ Anxiety	☐ Thyroid Disease	☐ COPD	☐ Osteoporosis
☐ Asthma	☐ Gout	☐ Kidney Disease	☐ Lupus
☐ Blood Clots	☐ Heart Disease	☐ Kidney Stones	☐ Rheumatoid Arthritis
☐ High Cholesterol	☐ Heart Failure	☐ Liver Disease	☐ Seizures
☐ Degenerative Arthritis	☐ Hepatitis	☐ Lung Disease	☐ Sexually Transmitted Infection
☐ Depression	☐ High Blood Pressure	☐ Migraine Headache	☐ Tuberculosis
☐ Glaucoma	☐ HIV/AIDS	☐ Neuropathy	☐ Vein Trouble
☐ Stroke	☐ Fibromyalgia	☐ A-Fib	☐ IBS/Inflammatory Bowel Disease
☐ BPH	☐ Sleep Apnea	☐ Neurological Disease	☐ Anemia

DIABETES (if yes, how long, **last A1C** & **TYPE**) :

CANCER (if yes, location, type, date of diagnosis, treatment) :

Psychiatric Disorders (if yes, current treatment and treating doctor) :

Other Medical Conditions not listed above:

PREVIOUS SURGERIES/INJURIES (and date):

DRUG ALLERGIES (also list reactions): ☐ None

FAMILY HISTORY:

Father: Alive? YES ~~Illnesses~~: _____ Age at Death _____ Cause _____

Mother: Alive? YES Illnesses: _____ Age at _____ _____

Number of Siblings/Health Issues: _____ Males: _____ Females: _____

Number of Children/Health Issues: _____ Males: _____ Females: _____

Other Relative Health Issues: _____

SOCIAL HISTORY: Single, Married, Divorced, Widowed, Living with: _____

Smoking: ☐ No ☐ Yes, Packs a day _____, How long _____ Circle Type: (pipe, cigar, cigarettes, vape, chew)

Recently quit ☐, Wants to quit ☐

Alcohol: ☐ No ☐ Yes, Drinks/day average _____ Circle Type: (beer, wine, liquor)

Substance Abuse: ☐ Y or ☐ N; List type of drug(s) used: _____

Occupation: _____

Caffeine: ☐ Y or ☐ N Drinks/day average _____ Circle Type: (tea, coffee, sodas, medicine, foods)

Diet: ☐ Y or ☐ N If yes, Circle Method of Diet: Low Carb, Low Calorie, Low Fat, Vegetarian, Other: _____

Exercise: ☐ Y or ☐ N Frequency _____ Duration _____ Type _____

HOSPITALIZATIONS THIS YEAR (list reason/date):

IMMUNIZATIONS AND DATES:

Gardasil _____ Hepatitis B _____ Influenza _____ Pneumovax _____ Measles _____

Meningococcal _____ Rubella _____ Tetanus _____ Shingles _____ COVID _____

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Reason for Visit: _____

Check any associated symptoms below

CONSTITUTIONAL: ☐ fevers/chills ☐ night-sweats ☐ anorexia ☐ weight loss ☐ weakness ☐ body aches ☐ sleep disorder ☐ weight gain

EYES: ☐ blurry vision ☐ double vision ☐ discharge ☐ eye pain ☐ light sensitivity ☐ eye irritation

EARS, NOSE, MOUTH & THROAT: ☐ decreased hearing ☐ runny nose ☐ mouth sores ☐ sore throat ☐ sinus congestion ☐ ringing in the ears ☐ nosebleeds ☐ difficulty swallowing ☐ hoarseness ☐ earache

CARDIOVASCULAR: ☐ chest pain ☐ palpitations ☐ decreased exercise tolerance ☐ lightheadedness ☐ shortness of breath ☐ swelling of hands or feet ☐ difficulty breathing while ☐ lying down ☐ fainting ☐ leg cramps with activity ☐ racing heart ☐ near fainting

RESPIRATORY: ☐ cough ☐ shortness of breath ☐ coughing up blood ☐ wheezing ☐ excessive ☐ sputum ☐ excessive snoring ☐ sleep disturbances due to breathing

GASTROINTESTINAL: ☐ nausea/vomiting ☐ difficulty swallowing ☐ heartburn ☐ diarrhea ☐ blood in stools ☐ abdominal pain ☐ regurgitation ☐ bloating ☐ constipation ☐ significant change in bowel habits ☐ hemorrhoid problems

GENITOURINARY: ☐ pain/burning with urination ☐ blood in urine ☐ frequency ☐ urgency ☐ unable to empty bladder ☐ trouble starting urinary stream ☐ nighttime urination ☐ foul urine odor ☐ kidney pain ☐ inability to control bladder ☐ genital sores ☐ lack of sexual drive ☐ missed period ☐ abnormal vaginal bleeding

MUSCULOSKELETAL: ☐ joint pain/swelling ☐ weakness ☐ stiffness ☐ arthritis ☐ gout ☐ loss of strength ☐ fluid in joint

DERMATOLOGIC: ☐ rashes ☐ suspicious skin lesions

NEUROLOGICAL: ☐ headaches ☐ poor balance ☐ numbness ☐ difficulty with coordination ☐ falling ☐ sensation of room spinning ☐ tremors ☐ memory loss ☐ excessive daytime ☐ sleeping ☐ weakness ☐ tingling in extremities

PSYCHIATRIC: ☐ anxiety ☐ depression ☐ thoughts of suicide ☐ thoughts of violence ☐ frightening visions or sounds ☐ sense of great danger ☐ other mental problems

ENDOCRINOLOGY: ☐ cold intolerance heat intolerance ☐ excessive urination ☐ excessive thirst ☐ significant weight change

HEMATOLOGY: ☐ enlarged lymph nodes ☐ excessive bleeding ☐ abnormal bruising ☐ fevers

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MEDICATIONS: See Below List Attached

NAME/DOSE/HOW IT'S TAKEN	NAME/DOSE/HOW IT'S TAKEN
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

HEALTH MAINTENANCE: (ENTER DATE OF YOUR LAST EXAM/STUDY)

☐ ☐ ☐ ☐ ☐

Assisted Device: (Please circle one) None, Walker, Power Scooter, Manual Wheelchair, Power Wheelchair

Bone Density: Date _____ Findings: _____ Performed by _____

Colonoscopy: Date _____ Findings: _____ Performed by _____

Eye Exam: Date _____ Findings: _____ Performed by _____

Diabetic Foot Exam: Date _____ Findings: _____ Performed by _____

Mammogram: Date _____ Findings: _____ Performed by _____

OBGYN Care: Date _____ Findings: _____ Performed by _____

PSA (men): Date _____ Findings: _____ Performed by _____

Other Physicians seeing you currently and their specialty:

Authorization to Release Information:

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from above authorizations and agreements.

Appointment Reminder Policy:

I authorize this Practice and their agent to place appointment reminder phone calls or text messages to the phone I have listed on my patient form.

Consent to Treatment:

I authorize the physicians of the Practice, their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: _____ **Date:** _____

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Acknowledgment of Receipt of Notice of Privacy Practices with Restrictions

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Oaks Family Healthcare, LLC's Notice of Privacy Practices, detailing how the above-named patient's information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Oaks Family Healthcare, LLC to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name	**Relationship**	**Contact #**

Contact Methods:

May we leave information on your answering machine at home? ☐Yes ☐No
May we leave information on your voicemail at work? ☐Yes ☐No
May we leave information on your cell phone? ☐Yes ☐No

I understand the contents of the Notice of Privacy Practices, and I request the following restriction(s) concerning the use and/or disclosure of my personal medical information (*include type of information covered and the parties who should not receive the information*):

_____

_____

_____

I understand that Oaks Family Healthcare, LLC will carefully consider my request, but is not obligated to accept the request unless the request is to restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations and the information pertains solely to a health care item or service for which Oaks Family Healthcare, LLC has been paid in full other than by the health plan.

The request stated herein ☐**does or** ☐**does not** restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations with the information pertaining solely to a health care item or service for which Oaks Family Healthcare, LLC has been paid in full other than by the health plan

My signature below is acknowledgment that I have received a copy of Oaks Family Healthcare, LLC 's Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices and contained in this

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)

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Patient Name: _____ DOB: _____

1. I authorize Oaks Family Healthcare, LLC to Request, Use or Disclose the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____

_____

Specified Dates and Providers to be Included:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

From (doctors' names) _____

Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be ☐ **Requested From** ☐ **Disclosed To and Used by** the following individual or organization:

Name: _____

Address: _____

For the purpose: _____

☐ At the request of the individual Phone number _____ Fax Number _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Dr. Kimberly F. Owens, Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness

STAFF MEMBER REQUESTING RECORDS: _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: 7/31/2023

The policy of Oaks Family Healthcare, LLC is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Oaks Family Healthcare, LLC.

Individually identifiable health and personal information are any information obtained by Oaks Family Healthcare, LLC in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Oaks Family Healthcare, LLC receives from you as our patient.

Oaks Family Healthcare, LLC collects personal information in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative, and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment, and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service, or healthcare provider to efficiently coordinate your treatment plan. We will obtain your written authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. We also maintain information about you in your medical chart. Oaks Family Healthcare, LLC limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

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We do not disclose personal information to third parties unless one of the following exceptions applies:

- We will receive an explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to Dr. Kimberly F. Owens, Oaks Family Healthcare, LLC, 2298 E University Dr., STE A-301A, Auburn, AL 36830.
- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners or funeral director to carry out their duties.
- We are obligated to abide by the terms of this notice. We will obtain a signed, written authorization from you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You will be provided with a copy of the signed authorization. You have the right to revoke the authorization in writing, at any time, and mail to Dr. Kimberly F. Owens, Oaks Family Healthcare, LLC, 2298 E University Dr., STE A-301A, Auburn, AL 36830.

We will notify you in the event you are affected by an unsecured breach of information. We reserve the right to change the terms of this Notice of Privacy Practice and to make new notice provisions effective for all health information that we maintain. The revised notice will be made available on our website/portal and any new notices will be distributed to you upon your return to the practice.

With some exceptions, you have right to inspect, review or obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the right to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive an accounting of the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. Oaks Family Healthcare, LLC is not obligated to agree to a requested restriction unless the disclosure to your health plan is for payment or health care operations and is not otherwise required by law and it pertains solely to a health care item or service has paid the health care provider/entity in full. We must receive a written request from you to administer these rights. Please ask to speak to the Privacy Officer or Office Manager for further information or to begin the process to exercise any of these rights.

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If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Privacy/Security Officer, Dr. Kimberly F. Owens at (334) 991-5951 or you may file a complaint in writing to our Privacy Officer, Dr. Kimberly F. Owens, Oaks Family Healthcare, LLC, 2298 E University Dr., STE A-301A, Auburn, AL 36830. You have the right to file a complaint with our office and the Office for Civil Rights (OCR) and there will be no retaliation for filing a complaint with either entity.

Other optional uses of PHI:

- ❑ Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior the use of your information in a research study. You will be required to sign and complete a written authorization. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You have the right to revoke the authorization in writing and then mail to the Privacy Officer at Oaks Family Healthcare, LLC, 2298 E University Dr., STE A-301A, Auburn, AL 36830, or this may be done at our office. You will be provided with a copy of the signed authorization.
- ❑ In order to coordinate your care or service your account, Oaks Family Healthcare, LLC and our agents may contact you by telephone at any telephone number you provide, including wireless telephone numbers, which could result in charges. Oaks Family Healthcare, LLC may also contact you by sending text messages or emails, using any e-mail address you provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.