NovaStar
FAMILY MEDICINE

Last Name: _____ **First Name:** _____

Date of Birth: _____ **SSN:** _____

Address: _____

City: _____ **State** _____ **Zip** _____

Home Phone: _____ **Can we leave message?** ☐ **Yes** ☐ **No**

Cell Phone: _____ **Can we leave message** ☐ **Yes** ☐ **No**

Email address _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Domestic Partner**

Preferred language: _____ **Race:** _____

Employer: _____ **Work Phone:** _____

Emergency Contact: _____ **Phone:** _____

Relationship to patient: _____

How did you hear about NovaStar Family Medicine LLC? _____

5046 N Peoria Ave Ste 100
Tulsa Ok 74126
539.424.5943

NovaStar FAMILY MEDICINE

HIPPA AUTHORIZATION

This authorization outlines who medical information about you may be shared.

Please read carefully.

This privacy of your medical information is important to us. Our Notice of Privacy Practices outlines how we may use or disclose medical information on a regular basis. This authorization is for situations not included in the Notice when you may want us to share your medical information with someone else such as a spouse, other family member, or your caregiver. This authorization allows the individual(s) listed to have access to all of your information as a patient of this practice and will be all inclusive unless otherwise specified in the Limitations section below. This authorization will remain in effect for a period of ***five years*** from the date signed.

Who may receive your health information? Who can pick up your prescriptions from our office?

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Limitations: _____

_____

_____

_____

I understand that one disclosed to the individual(s) named above, NovaStar Family Medicine, cannot guarantee that the individual(s) will maintain the confidentiality of such information as described by law.

REVOCATION

This authorization will remain for a period of five years from the date signed. However, you have the right to revoke this Authorization at any time if the revocation is made in writing and is received and acknowledged by NovaStar Family Medicine. Such revocation will restrict disclosures of your medical information but cannot affect past disclosures or disclosures underway at the time of receipt.

Patient Signature: _____ **Date of Birth:** _____ **Date:** _____

Legal Guarantor: _____ **Relationship:** _____ **Date:** _____

NovaStar Family Medicine
5046 N. Peoria Ave Ste 100
Tulsa, Oklahome 74126

Phone: 539-424-5943
Fax: 539-424-5946

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As Your Medical Home Primary Car Provider (PCP), we agree to:

- **Honor your rights as a patient, and treat you with dignity and respect**
- **We will focus on listening to your concerns, educating you on your health care needs and preventive services**
- **Focus on treating you as a whole person: physically, mentally, and emotionally**
- **Focus on providing you with *ongoing quality* and *safe* medical care including prevention of future health complications**
- **Work to schedule timely office appointments for your chronic and urgent healthcare needs**
- **Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication**
- **Provide you with referrals to specialists as deemed medically necessary by your PCP**
- **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:

- **Work with us, as your PCP, to meet all your health care needs.**
- **Communicate with us about all your healthcare concerns and goals**
- **Report any changes related to your health, treatments, medications (prescription, OTC, herbal and street drugs)**
- **This includes any medical equipment being used or that has been ordered or recommended for use**
- **Call us before going to the ER, unless its life threatening**
- **Notify us after any ER, Urgent Care, or Hospital visit**
- **Schedule medical appointments in a timely manner including follow-up appointments**
- **Keep appointments as scheduled with us and any specialist we have referred you to**
- **If you cannot keep an appointment, call before the appointment time, to cancel or reschedule the appointment**
- **You may be dismissed from NovaStar Fam Medicine if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement**

Signature: _____ **Date:** _____

Provider Signature: _____

5046 N Peoria Ave Ste 100
Tulsa Ok 74126
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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ **Patient Name:** _____ **Date of Birth:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Note difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly everyday
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Note difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

NovaStar
FAMILY MEDICINE

Medical Release of Information Form

Patient Name: _____ **Date of Birth:** _____

Social Security #: _____ **Previous Names:** _____

I request and authorize _____

(Name of previous physician and Practice Name)

Reason for release _____

To release the medical record of the above-named patient to:

Nova Star Family Medicine LLC

5046 N. Peoria Ave Ste 300

Tulsa, Oklahoma 74126

539-424-5946 fax

This request and authorization apply to: (initial appropriate lines)

_____ Specific Health Care Information relating to the following treatment conditions or dates of treatment

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This information may contain x-ray or laboratory reports, EKG reports, consults, and diagnostic info

_____ **All Health Care information** including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol abuse

_____ **I understand I have the right to revoke this authorization** by providing a written request to the above name physician or organization. I understand that the revocation will not apply to information that has already been released.

Signature of patient or authorized representative (include relationship) _____ Date _____

Unless otherwise revoked this authorization will expire six(06) months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact NovaStar Family Medicine at 539-424-5943.

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NovaStar FAMILY MEDICINE

Insurance

As a courtesy to our patients, NovaStar Family Medicine is happy to file insurance claims on your behalf. If you have a secondary insurance, let our staff know. We will need a copy of all cards. It is your responsibility to call your insurance company prior to the first visit to make sure we are in-network with your insurance. It is also your responsibility to make sure our office is aware of any changes in insurance coverage. Failure to do so will cause delays or denial of insurance payment.

You will be billed for any deductible or co-insurance amounts not covered by your insurance. If we are unable to verify insurance coverage prior to scheduled appointment, patients will be responsible for all fees associated with office visit due at time of service. _____ Initial

Medicaid/Medicare Patients

If you or your children are on Medicaid, your insurance card must have NovaStar Family Medicine LLC listed as your provider. We are unable to see patients until this is corrected.

If you are a Medicare Patient, please be sure to bring your Medicare card to every appointment as well as any supplemental insurance cards. _____ Initial

Prescriptions

NovaStar Family Medicine recommends you use one pharmacy for all prescription needs. Please be sure both the pharmacy and NovaStar Family Medicine are aware of any drug allergies you have.

If you need a prescription refill, please call your pharmacy and have them fax a request to our office at: 539-424-5946. Request received after 3pm will be assessed the next business day.

Narcotics will not be prescribed from NovaStar Family Medicine. If you have chronic pain, you will referred to a pain specialist to evaluate and treat condition.

No medication change will be complete until seen in clinic. Lost or Stolen meds will not be refilled for any reason. We will send all medication to your pharmacy of choice. It is your responsibility to keep medication safe. Do not ask staff to alter medications. _____ Initial

Signature _____ **Date:** _____

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MEDICAL HISTORY INFORMATION SHEET

NAME: **AGE:** **TODAY'S DATE:**

Birth Date: **Height** **ft** **inches** **Weight** **lbs**

REASON FOR TODAY'S EXAM

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

☐ High Blood Pressure	☐ DVT	☐ Lung Disease	☐ Stroke
☐ High Cholesterol	☐ Pulmonary Embolus	☐ Asthma	☐ Diabetes
☐ Vein Trouble	☐ Tuberculosis	☐ Heart Trouble	☐ Pneumonia
☐ Kidney Problems	☐ Nervous Disorder	☐ Seasonal Allergies	☐ HIV
☐ Thyroid Problems	☐ Sinus	☐ Arthritis	☐ Hepatitis
☐ Drug Abuse/Alcoholism	☐ Tonsillitis	☐ Gastrointestinal	☐ Osteoporosis
☐ Joint Replacement	☐ Bleeding Tendencies	☐ Cancer: If Yes, What Type	

Other:

History of Serious injuries/Illnesses? ☐ YES ☐ NO If yes, Please describe below.

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has ha.

☐ High Blood Pressure	☐ DVT	☐ Lung Disease	☐ Stroke
☐ High Cholesterol	☐ Pulmonary Embolus	☐ Asthma	☐ Diabetes
☐ Vein Trouble	☐ Tuberculosis	☐ Heart Trouble	☐ Pneumonia
☐ Kidney Disease	☐ Nervous Disorder	☐ Seasonal Allergies	☐ HIV
☐ Liver Disease	☐ Seizures	☐ Ear Problems	☐ Sinus
☐ Drug Abuse/Alcoholism	☐ Thyroid Problems	☐ Arthritis	☐ Tonsillitis
☐ Joint Replacement	☐ Hepatitis	☐ Gastrointestinal	☐ Osteoporosis
☐ Cancer: If Yes, What Type		☐ Bleeding Tendencies	

Other:

SOCIAL HISTORY:

Occupation: Marital Status: Children: Yes ☐ No ☐ Live Alone: Yes ☐ No ☐

Tobacco Use: Never ☐ In the Past ☐ Presently ☐ How Much? How long?

Alcohol Use: Daily ☐ Occasional ☐ None ☐ Other substance use or abuse? Yes ☐ No ☐

SYSTEM REVIEW: Please describe any active problem or symptom.

General Symptoms (i.e. fever, weight gain/loss, fatigue)

Eyes/Ears/Nose/Throat	Heart	Lung
Allergies/Rashes	Muscles/Bones/Joints	Psychiatric
Endocrine (Diabetes/Thyroid)	Bleeding/Lymph Nodes	Nerves
Skin and/or Breasts	OB/Genital/Urinary	Abdomen

ALLERGIC TO LATEX: **Yes** ☐ **No** ☐ **ALLERGIC TO MEDICATIONS:** **Yes** ☐ **No** ☐

PLEASE LIST:

CURRENT MEDICATIONS:

Save Reset Print