- Welcome To -

WellQuest

NEW CLIENT INFORMATION

We want to thank you for visiting us today. It is our goal to get you on your personalized path to wellness, and that starts today! We know - *forms are BORING*! But, they really do help us get to know you and your history so that we are better prepared to help you. Please take a few minutes and give us this important information so that we may best serve care for you today.

CLIENT INFORMATION

Last Name: _____ First: _____ Mi:___

Is this your legal name? ☐ Yes ☐ No If not, what is? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: _____ Sex: ☐ M ☐ F DOB: _____ Age: ____

Ethnicity: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other

Street Address: _____

PO Box: _____ City: _____ State: _____ Zip: _____

Email Address: _____

SSN#: ____-____-_____ Home Phone: _____ Mobile Phone: _____

Employer: _____ Employer Phone: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder Date-Of-Birth: _____

IN CASE OF EMERGENCY CALL

Other family members seen at WellQuest: _____

Name: _____ Relation: _____ Phone: _____

ACKNOWLEDGEMENT & SIGNATURE

The above information is true to the best of my knowledge. I understand that I am financially responsible for the balance on any charges I incur today (after insurance, if client is insured). I authorize WellQuest to release any information required to process my medical claims. And, if insured, and charges are filed with my health insurance - I authorize my insurance benefits be paid directly to WellQuest. I have received a copy of the "Patient Notice of our Privacy Practices" from WellQuest Medical and Primary Care Physicians of Tulsa Region.

Client Name: _____ Date: _____

Client Signature: _____

WHO CAN WE THANK FOR YOUR VISIT TODAY?
[We would like to send them a **THANK YOU** for the referral]

Leading Your Quest For Wellness

One down! Only 3 more to go...

YOUR MEDICAL HISTORY

Are you currently pregnant? ☐ Yes ☐ No If yes, how far along are you? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please tell list them here: _____

_____

Please list any medications and supplements that you are currently taking (prescriptions, over the counters, vitamins, herbal supplements, weight loss pills, etc.): _____

_____

_____

Have you ever experienced or been diagnosed with any of these conditions?

☐ High Blood Pressure	☐ Arthritis	☐ Hepatitis	☐ Kidney Stones
☐ Heart Disease / Blockages	☐ Pacemaker	☐ Anemia	☐ Heartburn
☐ Diabetes	☐ Ulcers	☐ Hiv	☐ Migraines
☐ Heart Attack	☐ Cancer	☐ Epilepsy / Seizures	☐ Chronic Back Pain
☐ Heart Murmur	☐ Emphysema	☐ Low Thyroid	☐ Lupus
☐ Irregular Heartbeat	☐ Asthma	☐ Kidney Disease	☐ Depression / Anxiety

Please tell us about any other diseases or conditions you've experienced: _____

_____

Please tell us about all of your surgeries and hospitalizations: _____

_____

Do you currently drink alcohol?	☐ Yes ☐ No	Are you currently sexually active?	☐ Yes ☐ No
If you said no, have you in the past?	☐ Yes ☐ No	Have you left the U.S. in the last 3 mo.?	☐ Yes ☐ No
If yes, how many drinks per week?	_____	Do you get significant sun exposure?	☐ Yes ☐ No
Do you currently use marijuana?	☐ Yes ☐ No	Do you exercise on a regular basis?	☐ Yes ☐ No
Do you use other illicit drugs?	☐ Yes ☐ No	Do you lead an active lifestyle?	☐ Yes ☐ No
Have you ever regularly used drugs?	☐ Yes ☐ No	How many children do you have?	_____
Do you currently use tobacco?	☐ Yes ☐ No	What is your occupation?	_____
If you said no, have you in the past?	☐ Yes ☐ No	Do you feel stress at work?	_____
If yes, how many cigarettes per day?	_____	Do you feel stress at home?	_____
Any other forms of tobacco?	_____	What brings you joy?	_____

Please tell us a about your family medical history to help us know your genetic makeup a bit better:

Father: ☐ Alive ☐ Deceased at Age ___ Medical conditions: _____

Mother: ☐ Alive ☐ Deceased at Age ___ Medical conditions: _____

Sibling: ☐ Alive ☐ Deceased at Age ___ Medical conditions: _____

Sibling: ☐ Alive ☐ Deceased at Age ___ Medical conditions: _____

...the more we know about where you've come from,
THE BETTER PREPARED WE ARE TO GET YOU WHERE YOU WANT TO GO!

You have passed the midway point!

And this page is a breeze, it's all checkboxes...

OVERALL		DERMATOLOGY		MALE ISSUES	
Sudden Weight Change	☐Yes ☐No	Rash	☐Yes ☐No	Difficulty With Erections	☐Yes ☐No
Loss Of Appetite	☐Yes ☐No	Itching	☐Yes ☐No	Diminished Sexual Drive	☐Yes ☐No
Fever	☐Yes ☐No	Hives	☐Yes ☐No	Penile Discharge	☐Yes ☐No
Weakness	☐Yes ☐No	Hair Loss	☐Yes ☐No	**FEMALE ISSUES**	
Night Sweats	☐Yes ☐No	Lumps	☐Yes ☐No	Premenstrual Syndrome	☐Yes ☐No
Fatigue	☐Yes ☐No	Jaundice	☐Yes ☐No	Infertility	☐Yes ☐No
EYES, EARS, NOSE & THROAT		**ENDOCRINOLOGY**		Painful Periods	☐Yes ☐No
Nose Bleeds	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Bleeding Between Periods	☐Yes ☐No
Sinus Pressure	☐Yes ☐No	Excessive Sweating	☐Yes ☐No	Irregular Periods	☐Yes ☐No
Runny Nose	☐Yes ☐No	Excessive Urination	☐Yes ☐No	Yeast Infections	☐Yes ☐No
Eye Irritation	☐Yes ☐No	Cold Intolerance	☐Yes ☐No	Vaginal Itching	☐Yes ☐No
Eye Drainage	☐Yes ☐No	Heat Intolerance	☐Yes ☐No	Pelvic Pain	☐Yes ☐No
Change In Voice	☐Yes ☐No	**MUSCULOSKELETON**		Abnormal Vaginal Discharge	☐Yes ☐No
Sore Throat	☐Yes ☐No	Joint Stiffness	☐Yes ☐No	**HEMATOLOGY**	
Difficuty Swallowing	☐Yes ☐No	Leg Cramps	☐Yes ☐No	Easy Bruising	☐Yes ☐No
CARDIOLOGY		Joint Pain	☐Yes ☐No	Swollen Glands	☐Yes ☐No
Palpitations	☐Yes ☐No	Joint Swelling	☐Yes ☐No	Fatigue	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Back Pain	☐Yes ☐No	**NEUROLOGY**	
Chest Pain	☐Yes ☐No	Neck Pain	☐Yes ☐No	Headaches	☐Yes ☐No
Shortness Of Breath		Muscle Aches	☐Yes ☐No	Tingling Or Numbness	☐Yes ☐No
With Activity	☐Yes ☐No	**UROLOGY**		Seizures	☐Yes ☐No
Leg Swelling	☐Yes ☐No	Difficulty Urinating	☐Yes ☐No	Dizziness	☐Yes ☐No
RESPIRATORY		Blood In Urine	☐Yes ☐No	Focal Weakness	☐Yes ☐No
Shortness Of Breath	☐Yes ☐No	Urinary Urgency	☐Yes ☐No		
Chest Tightness	☐Yes ☐No	Frequent Urination	☐Yes ☐No		
Cough	☐Yes ☐No	Urinary Incontinence	☐Yes ☐No		
Wheezing	☐Yes ☐No	**PSYCHIATRIC**			
Congestion	☐Yes ☐No	Depression	☐Yes ☐No		
COLON		High Stress	☐Yes ☐No		
Blood In Stool	☐Yes ☐No	Mood Swings	☐Yes ☐No		
Diarrhea	☐Yes ☐No	Suicidal Ideation	☐Yes ☐No		
Vomiting	☐Yes ☐No	Anxiety	☐Yes ☐No		
Constipation	☐Yes ☐No	Sleeping Difficulties	☐Yes ☐No		
Nausea	☐Yes ☐No	Obsessive Compulsive	☐Yes ☐No		
Abdominal Pain	☐Yes ☐No	Bad Dreams	☐Yes ☐No		
Change In Bowel Habits	☐Yes ☐No	Tightness In Chest	☐Yes ☐No		

Now you're moments from being complete!

Just read through our policies and responsibilities on the next page, sign and you're DONE!

Are you interested in our preventive and integrative steps to Wellness? ☐ Yes ☐ No

Again, we want to THANK YOU for coming to

WellQuest today and letting us be a part of your quest for wellness!

NEW CLIENT POLICY

WellQuest Medical is currently not accepting new clients that require chronic pain management. If you are currently on any controlled substance on a routine basis such as those listed below, we are unable to be your primary care physician.

Controlled substances are listed as Schedule II, III, IV by the Food and Drug Administration.

- This list includes but is not limited to pain medication such as: Hydrocodone, Oxycodone, Codeine, Oxycontin, etc.
- this list includes but is not limited to tranquilizers such as: Alprazolam, Xanax, Valium, Diazepam, etc.

If you require these on an ongoing basis, please inform the receptionist before completing this form. Some exceptions are made by submitting medical records from previous physicians and asking for review before appointment. A physician will then review your record and we will notify you if we are able to manage your medical care on a long term basis.

STATEMENT OF FINANCIAL RESPONSIBILITY

AS A SELF-PAYING PATIENT: I attest that I have not presented any evidence of insurance coverage, or, I have Soonercare or Medicaid, but neither Dr. Amber Bazler nor Dr. Todd Rippy are my Primary Care Physicians. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time services are rendered, and I possess the means to tender payment today. I understand that I will be asked a for $100 deposit prior to being seen at each visit. Any additional amounts due must be paid at the end of each visit. Any overpayment will be credited back at the end of each visit. If I have concerns about the amount of my charges incurred, I will ask a member of the medical staff before charges are incurred. **WellQuest Medical reserves the right to withdraw further care if patient does not fulfill the obligation made under the above financial arrangements.**

AS AN INSURED PATIENT: I understand that WellQuest Medical will assist me in submitting my medical claim to my insurance carrier. I hereby authorize payment directly to WellQuest Medical and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services. In the event that my health plan determines a service to be "not covered," I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. I understand that statement balances are due at time of receipt. **WellQuest Medical reserves the right to withdraw further care if the patient does not fulfill the obligation made under the above financial arrangements.**

COMMUNICATION & ACKNOWLEDGEMENT

If WellQuest needs to contact you about your lab results, testing, x-rays, etc - how would you like us to deliver that information? ☐ Call or leave a detailed message at this number: _____

☐ Text me at this number: _____ ☐ Email me at this address: _____

☐ I authorize _____ (name) to receive the following information from WellQuest:

☐ Appointment Information ☐ Billing Information ☐ Lab Tests or Results ☐ Prescription of Medication Information

If you have read the policies above and accept the responsibilities, please check this box: ☐

Client Name: _____ Date: _____

Client Signature: _____