Martha Robinson, M.D.

114 N. Grand, #508
Okmulgee, OK 74447

Appt. Date _____
Appt. Time _____

PATIENT INFORMATION

Patient Name: Last	First	MI	Date:
Mailing Address:	City	State	Zip
Date of Birth:	Social Security #:		
Marital Status: □ S □ M □ D □ W	Sex: □ Male □ Female	Student: □ Yes □ No	
Home Phone: **(Circle preferred phone #)**	Cell Phone:		
Email:			
Employer:	Employer Phone:		
Employer Address:	City	State	Zip

RACE

□ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other

INSURANCE CARD HOLDER: □ Self □ Spouse □ Parent

Card Holder's Name: Last	First	Middle	
Mailing Address:	City	State	Zip
Date of Birth:	Social Security #:		
Home Phone:	Cell Phone:		
Employer:	Employer Phone:		
Employer Address:	City	State	Zip

LEGAL GUARDIAN OR POWER OF ATTORNEY

Name:	Relationship:		
Mailing Address:	City	State	Zip
Home Phone:	Cell Phone:		
Employer:	Employer Phone:		

PHARMACY

Pharmacy Name:	City:	Phone:

EMERGENCY CONTACT

Name:	Relationship:	
Home Phone:	Work Phone:	Cell Phone:

SIGNATURES REQUIRED FOR

1) **Patient Authorization for Treatment and Release of Information & Financial Policy**
2) **HIPPA Regulations**
3) **Financial Policy**

- All copayments and surgical deductibles are due at the time of service, without exception.
- Please keep in mind that many insurance plans have different deductibles and copays for office visits – separate from surgical services (biopsies, mole removal, liquid nitrogen – "freezing"-, tag removal, etc. Therefore, you may have a copay and deductible for the office visit AND another deductible for any surgical procedure. We are unable to always inform you of what services are covered or not covered.
- You must present your CURRENT insurance card at each visit so we file the claim correctly. We are not responsible for refiling claims because of outdated or incorrect cards. We file participating plans as a courtesy to you.
- Statements are only sent to you once we have heard from the insurance company and you have a remaining balance. If we do not receive payment in full from you within 45 days, the account is turned over to our collection agency. Interest charges may apply.
- SELF PAY: Payment in full due at the time of service. We do not have a payment plan.
- I understand the above financial policy and agree to abide by it.

Signed _____ **Date** _____

PATIENT AUTHORIZTION FOR TREAMENT AND RELEASE OF INFORMATION:

By my signature, I authorize the practice of Martha Robinson MD (MMR) to provide general healthcare services to me; release any of my medical records or other personal/medical information for purposes of determining benefits for services, obtaining reimbursement from my insurance co., or any public agency or third-party payor necessary. I also authorize MMR, including any lab or diagnostic test facility performing services on my behalf, to release any of medical records or personal/medical information to other physicians, labs, or diagnostic facilities involved in my care or treatment for purposes of billing, developing an appropriate treatment plan/diagnosis, quality assurance, utilization review or other analysis designed to monitor and maintain quality of care. **IN AUTHORIZING THIS RELEASE OF INFORMATION, I UNDERSTAND THAT SUCH INFORMATION MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND AIDS.**

ASSIGNMENT OF BENEFITS: By signing below, I hereby authorize payment of any benefits for services rendered by MMR to be made directly to MMR and authorize MMR to refund any overpaid insurance benefits where the overpayment is subject to coordination of benefits.

SIGNATURE: By signing below, patient represents that patient is 18 years of age or over and legally capable to give consent to treatment and to authorize release of the above information and to agree to all financial policies of MMR. By signature of parent or legal guardian, such individual represents that patient is under age 18 (a minor) or has a court-appointed guardian and agrees to all above policies. I have read and understand and agree to all of the above information.

_____	_____	_____
PATIENT/parent or legal guardian signature	**Relationship to patient**	**Date**

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Martha Robinson, MD, PC

I am a patient or the parent of a patient or legal guardian of a patient of Martha Robinson, MD. I hereby acknowledge receipt of the doctor's Notice of Privacy Practices.

Name of Patient (please print): _____ **Relationship to Patient:** □ **Self** □ **Parent** □ **Legal Guardian**

Signature: _____ **Date:** _____

Past Medical History

- □ None
- □ Anxiety disorder
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ Benign prostatic hyperplasia
- □ Cerebrovascular accident
- □ Chronic obstructive lung disease
- □ Coronary arteriosclerosis
- □ Depressive disorder
- □ Diabetes mellitus
- □ Disease caused by 2019-nCoV
- □ Elevated blood pressure
- □ End-stage renal disease
- □ Epilepsy
- □ Gastroesophageal reflux disease
- □ Hearing loss
- □ Human immunodeficiency virus infection
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Inflammatory disease of liver
- □ Leukemia
- □ Malignant lymphoma
- □ Malignant tumor of breast
- □ Malignant tumor of colon
- □ Malignant tumor of lung
- □ Malignant tumor of prostate
- □ Radiation therapy treatment management
- □ Transplantation of bone marrow
- □ Other_____

Past Surgical History

- □ None
- □ Abdominoperineal resection
- □ Bilateral replacement of knee joints
- □ Biopsy of breast
- □ Biopsy of prostate
- □ Coronary artery bypass graft
- □ Entire transplanted kidney
- □ Excision of basal cell carcinoma
- □ Excision of melanoma
- □ Excision of squamous cell carcinoma
- □ H/O: colostomy
- □ H/O: tubal ligation
- □ History of appendectomy
- □ History of bilateral mastectomy
- □ History of cholecystectomy
- □ History of colectomy
- □ History of liver excision
- □ History of percutaneous transluminal coronary angioplasty
- □ History of tissue graft heart valve replacement
- □ History of total cystectomy
- □ History of transurethral prostatectomy
- □ Hysterectomy
- □ Kidney biopsy
- □ Low anterior resection of rectum
- □ Lumpectomy of breast
- □ Lumpectomy of left breast
- □ Lumpectomy of right breast
- □ Mastectomy of left breast
- □ Mastectomy of right breast
- □ Mechanical heart valve replacement
- □ Oophorectomy
- □ Pancreatectomy
- □ Percutaneous extraction of kidney stone with fragmentation procedure
- □ Portosystemic shunt operation
- □ Prostatectomy
- □ Prosthetic arthroplasty of bilateral hips
- □ Splenectomy
- □ Surgical biopsy of skin
- □ Total nephrectomy
- □ Total orchidectomy
- □ Total replacement of left hip joint
- □ Total replacement of left knee joint
- □ Total replacement of right hip joint
- □ Total replacement of right knee joint
- □ Transplantation of heart
- □ Transplantation of liver
- □ Breast implants
- □ Breast reduction
- □ Other_____

Martha M Robinson, M.D.

Skin Disease History

□ None
□ Acne
□ Actinic keratosis
□ Asteatosis cutis
□ Basal cell carcinoma of skin
□ Contact dermatitis due to poison ivy
□ Dysplastic nevus of skin
□ Eczema
□ H/O: asthma
□ H/O: hay fever
□ Malignant melanoma
□ Pruritus of scalp
□ Psoriasis
□ Squamous cell carcinoma
□ Sunburn of second degree
□ Other_____

Do you wear sunscreen? □ Yes □ No If yes, what SPF?_____
Do you tan in a tanning salon? □ Yes □ No
Do you have a family history of Melanoma? □ Yes □ No If yes, which relative(s)?_____

Review of Systems

Artificial joints within past two years	□ Yes	□ No	Chest pain	□ Yes	□ No
Pregnancy or planning a pregnancy	□ Yes	□ No	Cough	□ Yes	□ No
Problems with bleeding	□ Yes	□ No	Depression	□ Yes	□ No
Problems with scarring (hypertrophic or keloid)	□ Yes	□ No	Fever or chills	□ Yes	□ No
Blood thinners	□ Yes	□ No	Headaches	□ Yes	□ No
GI upset with antibiotics	□ Yes	□ No	Hay fever	□ Yes	□ No
Yeast infections with antibiotics	□ Yes	□ No	Joint aches	□ Yes	□ No
Problems with healing	□ Yes	□ No	Muscle weakness	□ Yes	□ No
Rapid heartbeat with epinephrine	□ Yes	□ No	Neck stiffness	□ Yes	□ No
Immunosuppression	□ Yes	□ No	Night sweats	□ Yes	□ No
Changing mole	□ Yes	□ No	Seizures	□ Yes	□ No
Rash	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Abdominal pain	□ Yes	□ No	Sore throat	□ Yes	□ No
Anxiety	□ Yes	□ No	Thyroid problems	□ Yes	□ No
Bloody stool	□ Yes	□ No	Unintentional weight loss	□ Yes	□ No
Bloody urine	□ Yes	□ No	Wheezing	□ Yes	□ No
Blurry vision	□ Yes	□ No			

Do you have any of the following?

Allergy to lidocaine	□ Yes	□ No
Pacemaker	□ Yes	□ No
Defibrillator	□ Yes	□ No
Artificial heart valve	□ Yes	□ No
Allergy to adhesive	□ Yes	□ No
Allergy to topical antibiotic ointments	□ Yes	□ No
Premedication prior to procedures	□ Yes	□ No

Martha M Robinson, M.D.

Primary Care Doctor

Doctor: _____ Phone: _____ Fax: _____

Address: _____

Vaccine History

Influenza Vaccine □ Yes □ No DATE_____

Pneumococcal Vaccine □ Yes □ No DATE_____

Social History

Number of alcoholic drinks: □ none □ <1/day □ 1-2/day □ 3 or more/day

Currently smoke □ Yes □ No

Smoked in the past □ Yes □ No

Drug use □ Yes □ No

Other_____

Allergies

_____ _____ _____

_____ _____ _____

Medications

For ages 18 and under: Height_____ Weight_____

Please list ALL MEDICATIONS (including over the counter medications):

	NAME OF MEDICATION	DOSAGE	TAKEN HOW OFTEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

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