STEPHANIE TAYLOR, M.D. **JESSICA ENIX, M.D.**

PHONE: (405) 265-2210
FAX: (405) 696-9092

Dear Patient,

On behalf of our entire team, welcome to Surgical Partners of Oklahoma. We are honored that you and your referring physician have chosen us for your surgical care. Our goal is to provide you with the highest quality medical treatment in a supportive and professional environment, and we understand that undergoing surgery can be a significant event. We are committed to making your experience as comfortable and clear as possible by providing thorough information at every step of your journey.

Your First Visit

During your initial consultation, your surgeon will review your medical history, discuss your diagnosis, and go over all available treatment options. We encourage you to bring a list of questions and a trusted friend or family member to help take notes.

Practice Information & Policies

To help our office run smoothly, please keep the following in mind:

- **Arrival:** Please arrive [15] minutes before your scheduled appointment to complete any necessary paperwork.
- **Insurance: Although we make every effort to ensure we have the correct referrals, approvals and pre-authorizations for each patient, it is imperative, you, as the subscriber, be familiar with your specific insurance plan. Medical fees not covered by insurance are the responsibility of the patient and will be billed accordingly.**
- **What to Bring:** Please bring your photo ID, current insurance card, and a list of all medications you are currently taking.
- **Cancellations:** If you need to reschedule, we kindly ask for [24/48] hours' notice so we can offer that time to another patient.

Our Commitment to You

Communication is a vital part of your recovery. If you have any questions regarding your upcoming procedure, or post-operative care, please do not hesitate to call our office at 405-265-2210

Thank you for trusting us with your health. We look forward to meeting you soon.

Sincerely,

Surgical Partners of Oklahoma

SURGICAL PARTNERS OF OKLAHOMA

Name _____ Date: _____ Age: _____ Weight: _____ Height: _____

Accompanied by: _____ Relationship to patient: _____

PERSONAL HISTORY: PLEASE NOTE ALL CURRENT OR PAST MEDICAL CONDITIONS

Y N Heart Trouble
Y N Irregular heartbeat
Y N High blood pressure
Y N Stroke
Y N Rheumatic Fever
Y N Lung disease
Y N Asthma
Y N Pneumonia
Y N Blood vessel disease(Phlebitis)
Y N Jaundice
Y N Pancreatitis
Y N Ulcers
Y N Back trouble
Y N Muscle weakness
Y N Paralysis
Y N Epilepsy or seizures
Y N Arthritis
Y N Glaucoma
Y N Blood disease (anemia)
Y N Blood Transfusion
Y N Sickle cell trait or disease
Y N Kidney disease
Y N Dialysis _____days
Where_____
Y N Urinary problems
Date treated_____
Y N Diabetes
Y N Cancer
Y N Other Medical Issue_____
_____
Y N Abnormal chest X-ray
Y N Abnormal EKG
Y N Abnormal bleeding tendencies
Y N Anticoagulant therapy
Y N NSAIDS
Y N Blood thinners or aspirin
Y N Positive HIV/AIDS blood test

Y N Reaction to tape, bandaids
gloves, balloons, latex
Y N Fracture of facial bones
Y N Fracture of neck or back
Y N Motion sickness
Y N Pacemaker
Y N Implanted defibrillator
Y N Joint replacement
Y N Heart valve replacement
Y N Pregnant currently
Y N Bronchitis
Y N Emphysema
Y N Tuberculosis
Y N Hepatitis
Y N Cirrhosis
Y N Gallbladder problems
Y N Any abnormal reactions to
anesthesia or sedation medication

Do you have:

Y N False or loose teeth
Y N Dental Bridges
Y N Glasses or contacts
Y N Body piercing
Y N Hearing aid

Do You:

Y N Smoke _____pack(s) per day
Y N Former Smoker_____
Y N Drink alcohol
Y N Use recreational (street) drugs
List_____
_____
_____

List allergies (drug, food)

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List medications & dosages

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List prior surgeries & dates

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List all Doctors you are currently seeing

Primary Care_____
Cardiologist_____
Pulmonologist_____
Pain Mgmt_____
Oncologist_____
Other_____

Patient signature_____

PATIENT INFORMATION

Date _____ Pharmacy Name _____

Pharmacy Location _____

Patient Name _____

First Middle Last

Mailing Address _____

City _____ State _____ Zip _____ Email _____

Preferred Phone: _____ Other Phone _____

Birthdate _____ SSN _____ Single Married Widowed Divorced

Age _____ Sex _____ Race _____ Primary Language _____

Employed by _____ Work Phone _____

Referred by _____

Do you have an Advanced Directive (Yes/No) _____ If yes, on file with _____

Spouse _____ if under 18, Parent _____

EMERGENCY CONTACT (OUTSIDE THE HOME)

Name _____ Relationship to patient _____

Phone number _____

Please complete below if insured and/or responsible party is DIFFERENT than patient

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)

Name _____ Relationship to patient _____

Birthdate _____ SSN _____ Phone _____

Mailing Address _____

City _____ State _____ Zip _____

MEDICAL INSURANCE INFORMATION (IF NO CARD OR PATIENT IS NOT SUBSCRIBER)

Medical Insurance Carrier _____

ID # _____ Group # _____ Employer _____

Name of insured (if different than patient) _____

Patient relationship to insured _____ Insured Sex _____

Insured birthdate _____ Insured SSN _____

RELEASE OF INFORMATION

(We cannot file insurance without a copy of your insurance card(s) for verification of coverage.)

I hereby authonze my physician to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A copy of this authorization shall be considered as valid as the original document. I hereby authonze payment directly to my physician for this illness or injury, for the physician's benefits otherwise payable to me, but not to exceed my indebtedness to said physician. I agree to pay the physician for all my charges whether or not covered by the assignment. The responsible party hereby agrees that the physician office or the party responsible for the billing of these services may check credit with a source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information about a medical condition that is considered a communicable venereal disease, including, but not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state all the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authonzations. I have been notified that I may receive services from the Nurse Practitioner or Medical Assistance at this office.

Patient or Authorized Person Signature _____ Date _____

HIPAA CONSENT

I, _____ (patient or authorized person), give permission to Surgical Partners of Oklahoma and/or staff to leave information pertaining to my health including, but not limited to, dates and times of appointments, lab/x-ray results and other information as they feel necessary, on my answering machine and/or e-mail. I understand this could result in unintentional disclosure of my personal health information

Patient or Authorized Person Signature _____ Date _____

If you have any objections to the above, please list _____

I also give permission to Surgical Partners of Oklahoma and/or staff to discuss my health conditions with the following people: (examples: spouse, parent, children, sibling)

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices posted in our facility describes how Surgical Partners of Oklahoma may use and disclose your medical information and how you can get access to this information. Please review it carefully.

A complete copy of the Facility's Notice of Privacy Practices is posted in the office. By signing below, you acknowledge the Facility's Notice of Privacy Practices has been made available to you and a copy will be provided to you at your request.

Patient or Authorized Person Signature _____ Date _____

If authorized person, relationship to patient _____

SURGERY OPIOID CONSENT FORM

Patient Name:	Date of Birth:
The doctor may prescribe Opioids to control and manage post-surgical pain.	
Alternative options to opioids are Over the counter pain medications such as Tylenol, Advil, Excedrin.	

Instructions: *Please review the information listed below and put your initials next to each item when you feel you understand and accept what each statement says.*

	Initials
My surgeon will prescribe an opioid medication to help me control and manage post-surgical pain.	
This medicine is used to decrease and manage my pain but will not take away my pain completely.	
I will stop using the opioid medicine as soon as my pain is manageable and will use over the counter pain relievers if possible to manage the pain.	
I will contact my provider if the medicine does not control my pain when I take it as prescribed or if I have any adverse reactions to it.	
I will follow-up with my provider for post-surgical consultations as instructed or requested by my provider.	
If I do not use all of the medicine prescribed, I will ensure that it is disposed of properly in order to prevent its misuse by someone else.	
I will safely store the medicine to minimize the risk that children or other people will take it.	
When I take this medicine it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.	
When I take this medication, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.	
I may become physically or psychologically dependent or addicted to this medicine if I take them continuously so I agree to stop using them at the earliest possible time and to take no more than is necessary to control my pain.	
I have told my provider if I or anyone in my family has had any problems with mental illness or with controlling drug or alcohol use in the past.	
Taking too much of my pain medication, or mixing my pain medications with drugs, alcohol, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.	
It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.	
I will not use any illegal substance, such as cocaine, etc., while taking this medicine.	
If I travel out of the country while taking this medicine, I will notify the appropriate travel authority (usually the consulate website of the country) and obtain a note from my provider before travel, as traveling out of country with opioids may pose problems.	
For females: I understand it is my responsibility to inform my provider if I am pregnant.	

Signature of patient or guardian	Date
Printed name of patient or guardian:	

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Stephanie Taylor and Dr. Brady Hagood have an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Dated:_____

HPI COMMUNITY HOSPITAL INTEGRIS

Pre-Admission Testing Decision Tool

HPI NORTHWEST SURGICAL HOSPITAL INTEGRIS

Today's Date: Date of Surgery:

Name:_____ DOB:_____ Ht:_____ Wt:_____ Surgeon:_____

Medical History (Section 1)		
Kidney disease or dialysis	Yes	No
Liver disease	Yes	No
Diabetic/Pre-Diabetic/insulin resistant	Yes	No
Anemia/HIV/bleeding disorder	Yes	No
Lung disease (uncontrolled asthma/COPD/ Emphysema) or symptoms of lung disease	Yes	No
History of heart disease, Coronary Artery Disease, Congestive Heart Failure, stent placement, heart attack, abnormal stress test, or abnormal EKG	Yes	No
History of TIA or stroke (within last 12 months)	Yes	No
History of blood clots (within last 12 months)	Yes	No
History of cancer that required radiation or chemotherapy (within last 12 months)	Yes	No
Current alcohol or drug ABUSE	Yes	No
Pacemaker or Automatic Implantable Cardioverter Defibrillator (AICD)	Yes	No
History of Seizures	Yes	No
Medications (Section 2)		
NSAIDS	Yes	No
Anticonvulsants	Yes	No
Diet pills (i.e. Phentermine, Adipex, Qsymia)	Yes	No
GLP-1 (Semaglutide, Ozempic, Mounjaro, etc.)	Yes	No
SGLT-2 (Jardiance, Farxiga, Synjardy, etc.)	Yes	No
Diabetes (Metformin, Glimepiride, Januvia, etc.)	Yes	No
Blood Pressure	Yes	No
Diuretics (water pill)	Yes	No
Nitrates or other heart medication	Yes	No
Digoxin	Yes	No
Anticoagulants (blood thinners)	Yes	No

Metabolic Activity (Section 3)- Are you able do the following without stopping to rest? Circle the highest number you are able to achieve.		
1. Feed, dress yourself	Yes	No
2. Walk indoors around the house	Yes	No
3. Walk 2 blocks on level ground	Yes	No
4. Climb a flight of stairs without stopping or walk up a hill	Yes	No
5. Run a short distance	Yes	No
6. Do moderate extended work around the house such as vacuuming, sweeping, and dusting	Yes	No
7. Do heavy work around the house such as scrubbing floors, or moving heavy furniture	Yes	No
8. Do yard work such as raking leaves, weed-eating, or pushing a high power mower	Yes	No
9. Participate in moderate recreational activities such as doubles tennis, dancing, bowling, walking golf course	Yes	No
10. Participate in strenuous sports such as swimming, singles tennis, football, basketball, or skiing	Yes	No
If you answered "No" to any of the above questions in section 3, is the limitation due to pain in the extremities?	Yes	No
Does any activity listed in section 3 cause shortness of breath, chest tightness, or chest pain?	Yes	No

*Internal office use: If yes to this question, patient will need Pre-Admission Testing

Addition Information:

Outsourced labs: Where _____ When _____