E. Bradley Garber, M.D.

(Please Print)

Patient's Name_____ ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss.

Address _____

Zip Code _____ City _____ State _____

Billing Address if Different from above:_____

Occupation _____

Email Address: _____

Phone Number(s)

Home ( ) _____

Office ( ) _____

Cell ( ) _____

Sex ❑ Male ❑ Female **Age** _____

Date of Birth _____-_____-_____

Social Security Number _____

Marital Status ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid

Spouse's Name_____

Insurance Company Name---Address--Zip ---Phone Number ***We will make a copy of cards if available***

Primary Company_____

ID #:_____

Group#:_____

Secondary Company_____

ID#:_____

Group#: _____

Copay Amount **$** _____

Referred by _____

I hereby authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits, otherwise payable to me, to be made payable to:

E. Bradley Garber, M.D. 1784 South Utica, Tulsa, OK 74104-5336

Signature_____ **Date** _____

MEDICAL HISTORY
FOR E. BRADLEY GARBER, M.D.

PATIENT'S NAME:_____

TODAY'S DATE:_____

DATE OF BIRTH:_____

PLEASE LIST YOUR MEDICAL ILLNESSES:

_____

_____

_____

_____

MEDICATIONS YOU ARE TAKING:

_____

_____

_____

ALLERGIES TO MEDICATIONS:_____

_____

_____

_____

PRIOR OPERATIONS:

_____

_____

_____

_____

Cigarettes_____

REASON FOR CONSULTATION_____

E. Bradley Garber, M.D.

PLASTIC AND RECONSTRUCTIVE SURGERY

ST. JOHN MEDICAL CENTER • 1784 SOUTH UTICA • TULSA, OK 74104-5336 • (918) 745-2117 • FAX: (918) 745-2178

PROTECTED HEALTH INFORMATION

Physicians are now required by law to inform their patients about policies regarding the privacy of your medical records. Our office has been, and continues to be bound, by professional standards of confidentiality that are even more stringent than those required by law. Your privacy is an important concern and will be protected in this office. We retain records relating to professional services that we provide so that we are better able to assist you with your medical care, and in some cases, to comply with professional guidelines. We maintain physical, electronic and procedural safeguards that comply with these professional standards.

Your medical records will <u>not</u> be released to any party without your signed and dated consent.

In order to file insurance for you, you will need to sign and date the bottom of the pink encounter form. We will make a reasonable effort to limit the amount of information disclosed to the insurance company and only supply the minimal information necessary to process your insurance claim.

In some cases, we will supply your medical information to your referring doctor to promote good patient care and continuity. If you do not want us to do this, please inform us.

You have a right to access and obtain copies of your medical records. There is a charge for copying your records. The original records are retained in our office under secure, fireproof conditions. You have a right to amend and correct any erroneous information that you identify in your records, and this can be done by having a conference with your doctor. You have the right to request restriction of use of your medical records. This form is revocable upon your request. Upon request, you are entitled to a copy of this form.

Please discuss any privacy issues with us if you have questions.

I have read this Privacy Statement on Protected Health Information and I accept the terms as outlined above.

Signed: _____

Date : _____