

Skiatook Family Clinic

A Federally Certified Rural Health Clinic
201 East Second Street • Skiatook, OK 74070
Phone: (918) 396-1262 | Fax: (918) 238-6577

Re: Welcome to Skiatook Family Clinic

Dear Prospective Patient,

Thank you for choosing Skiatook Family Clinic. Since 2016, we have been a locally owned and operated practice, growing alongside our community, and in 2023 we became a federally certified Rural Health Clinic. Our providers bring over 25 years of combined experience caring for primary care patients of all ages, and we are honored by your interest in joining our practice.

Our philosophy centers on supporting people with small-town values. We understand the challenges of distance and travel time, and we strive to be timely, treat our patients within our community, and support local healthcare businesses when possible.

We provide comprehensive primary care for a wide range of health conditions, including high blood pressure, diabetes, cholesterol management, weight management, mental health concerns, and many other common illnesses. We also offer preventive and wellness visits, and lab draws are available on site Monday through Thursday mornings.

While we handle most care in-house, we refer patients off-site for imaging, women's health checkups, and specialty consultations such as orthopedics and surgery when clinically indicated.

We accept new patients age six and older on a case-by-case basis. If you would like to join our practice, please complete the attached documents and return them to our office at your earliest convenience for consideration and scheduling of your first appointment. If you need help with these forms, including help in another language or format, please call us at (918) 396-1262.

Sincerely,

Layne Subera, DO
Owner and Medical Director

**** Electronic Signature Verified ****

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Patient Information

About You

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Social Security #: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Preferred Language: _____

Employer: _____ Work Phone: _____

Who referred you to us? _____

Sex: ☐ Male ☐ Female Do you need an interpreter? ☐ Yes ☐ No

Emergency Contact (someone NOT living with you)

Name: _____ Relationship: _____

Phone: _____ Other Phone: _____

Responsible Party (only if someone other than the patient pays the bill)

Name: _____ Relationship: _____

Phone: _____ Date of Birth: _____

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Insurance Information

Please bring your insurance card(s) and a photo ID to your visit. We will make a copy.

Primary Insurance

Insurance Company: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____ Holder Date of Birth: _____

Patient is the policy holder's: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (if any)

Insurance Company: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____ Holder Date of Birth: _____

Patient is the policy holder's: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medicare / SoonerCare

☐ I have Medicare. Medicare #: _____

☐ I have SoonerCare (Oklahoma Medicaid). Member #: _____

☐ I do not have insurance, or I will not be using insurance. (You may ask for a Good Faith Estimate of your costs.)

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Health History

Patient Name: _____ Date of Birth: _____

Why are you coming to see us?

How long has this been going on? _____

Allergies

☐ I have no known allergies

List anything you are allergic to (medicines, foods, latex, etc.) and what happens:

Habits

Tobacco or vaping: ☐ Never ☐ Quit ☐ Current How much? _____

Would you like help quitting? ☐ Yes ☐ No

Alcohol: ☐ None ☐ Yes Drinks per week: _____

Have you ever used street drugs or taken a prescription medicine differently than prescribed? ☐
Yes ☐ No

Pain

Circle your pain level today: 0 1 2 3 4 5 6 7 8 9 10

0 = no pain, 10 = worst pain you can imagine

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Medical History

Patient Name: _____ Date of Birth: _____

Have you ever had any of these? (check all that apply)

- | | |
|---|--|
| ☐ High blood pressure | ☐ Diabetes |
| ☐ High cholesterol | ☐ Heart disease or heart attack |
| ☐ Stroke | ☐ Asthma or COPD |
| ☐ Thyroid disease | ☐ Kidney disease |
| ☐ Liver disease or hepatitis | ☐ Cancer |
| ☐ Depression or anxiety | ☐ Arthritis |
| ☐ Seizures | ☐ Acid reflux |
| ☐ Sleep apnea | ☐ Blood clots |

Other conditions: _____

Surgeries or hospital stays (what and when)

Family history (check if a parent, brother, or sister has had it)

- | | |
|---|---|
| ☐ Heart disease | ☐ Diabetes |
| ☐ High blood pressure | ☐ Stroke |
| ☐ Cancer (type: _____) | ☐ Mental illness |
| ☐ Alcohol or drug problems | ☐ Other: _____ |

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How Are You Feeling?

Patient Name: _____ Date of Birth: _____

Check any problems you are having **now**:

General	☐ Fever or chills	☐ Tired all the time
	☐ Weight loss	☐ Weight gain
Eyes, ears, nose, throat	☐ Vision changes	☐ Hearing loss
	☐ Sore throat	☐ Stuffy nose
Heart and lungs	☐ Chest pain	☐ Racing or skipping heartbeat
	☐ Shortness of breath	☐ Cough
Stomach	☐ Heartburn	☐ Nausea or vomiting
	☐ Diarrhea or constipation	☐ Blood in stool
Urinary	☐ Burning	☐ Going often
	☐ Blood in urine	☐ Up at night to go
Muscles and joints	☐ Joint pain	☐ Swelling
	☐ Back pain	☐ Muscle aches
Skin	☐ Rash	☐ Changing mole
	☐ Lump	☐ Itching
Nerves	☐ Headaches	☐ Dizziness or fainting
	☐ Numbness or tingling	☐ Weakness
Mood and sleep	☐ Feeling down	☐ Anxiety or worry
	☐ Trouble sleeping	☐ Memory problems

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Current Medication List

Patient Name: _____ Date of Birth: _____

List **every** medicine you take, including vitamins and over-the-counter products. Or bring all your medicine bottles to your visit.

☐ I do not take any medicines

Medicine Name	Strength	How Often	Prescribed By

Pharmacy name and location: _____

For office use: Reviewed by _____ Date _____

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Medication Safety Questions

These questions help us prescribe medicines as safely as possible for you. Check Yes or No for each one.

Patient Name: _____ Date of Birth: _____

Has anyone in your family (parents, brothers, sisters) had:	Yes	No
A problem with alcohol	☐	☐
A problem with street drugs	☐	☐
A problem with prescription medicines	☐	☐

Have you ever had:	Yes	No
A problem with alcohol	☐	☐
A problem with street drugs	☐	☐
A problem with prescription medicines	☐	☐

Mental health:	Yes	No
ADHD, OCD, bipolar disorder, or schizophrenia	☐	☐
Depression	☐	☐

For office use: Age 16-45 (+1) ____ Total score ____ Risk: Low 0-2 / Moderate 3-4 / High 5+ Reviewed by _____

Adapted from the Opioid Risk Tool, Revised (ORT-R): Cheattle MD, et al. J Pain. 2019;20(7):842-851.

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Authorization to Share Medical Records

Patient Name: _____ Date of Birth: _____

Parent/Guardian (if patient is a minor): _____

I authorize Skiatook Family Clinic to:

☐ Get my records from ☐ Send my records to

Name/Office: _____

Address: _____

City/State/ZIP: _____ Phone/Fax: _____

Which records?

☐ All medical records ☐ Only these: _____

Why?

☐ Continuing my care ☐ My own use ☐ Other: _____

I understand that these records may include information about mental health, HIV/AIDS, and genetic testing, to the extent permitted by law. Substance use disorder treatment records protected by 42 C.F.R. Part 2 are released only with a separate written consent that meets federal requirements. I may cancel this authorization in writing at any time, except for records already released. Records released may be shared again by the recipient and may no longer be protected by federal privacy rules. My care will not depend on whether I sign. This authorization ends on the date below or, if none is written, one year after I sign.

This authorization ends on (date): _____

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

A parent or legal guardian signs if the patient is a minor.