# Skiatook Family Clinic

201 East Second Street • Skiatook, OK 74070
Phone: (918) 306-1262 | Fax: (918) 306-4598

January 31, 2026

**Re: New Patient Welcome**

Dear Prospective Patient,

Thank you for choosing Skiatook Family Clinic. Since 2016, we've been a locally owned and operated practice, growing alongside our community. Our providers bring over 25 years of combined experience caring for complex ambulatory primary care patients, and we're 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 care for a wide range of health conditions, including high blood pressure, diabetes, cholesterol management, obesity, mental health concerns, and many other common ailments. All of our providers have additional training in addiction medicine and can provide medication-assisted treatment for patients with opioid use disorder when needed. A licensed counselor is also available for certain patients on-site.

While we handle most care in-house, we do refer patients off-site for imaging, women's health checkups, and specialty consultations such as orthopedics, surgery, and chronic pain management services 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.

Sincerely,

Layne Subera, DO

***** Electronic Signature Verified *****

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## New Patient History Form

Patient Name: _____ DOB: _____ Date: _____

### History of Present Illness

*Please help us understand your current health concerns.*

Reason for today's visit:

_____

_____

How long have you had these symptoms?

_____

Where is the problem located?

_____

Severity: [ ] Mild [ ] Moderate [ ] Severe When do symptoms occur?

_____

What makes symptoms better or worse?

_____

Related symptoms?

_____

### Allergies

*Note: Allergies typically cause symptoms like swelling, wheezing, shortness of breath, or rash.*

List any medication or other allergies:

_____

_____

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## New Patient History Form (continued)

### Current Medications

Please list all medications you take, including dosages and frequency:

_____

_____

*(Use medication list form for complete list if needed)*

### Lifestyle & Habits

Tobacco use: [ ] None [ ] Current _____ packs/day Would you like help quitting? [ ] Yes [ ] No

Alcohol use: [ ] None _____ drinks/week (1 drink = 4 oz wine, 12 oz beer, or 2 oz spirits)

### Pain Assessment

Current pain level (0 = none, 10 = worst possible):

[ ] None [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10

### Substance Use History

Have you ever used illicit substances or prescription medications not as prescribed? [ ] Yes [ ] No
If yes, please describe:

_____

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## Medical History

### Past Medical History

Please list any previous medical diagnoses or health conditions:

_____

_____

### Family Medical History

Please list health conditions that tend to run in your family:

_____

### Review of Systems

*Please check any symptoms you are currently experiencing:*

| | |
|---|---|
| **General** | [ ] Weight loss [ ] Weight gain [ ] Fever [ ] Chills [ ] Fatigue |
| **Ears/Throat** | [ ] Hearing loss [ ] Congestion [ ] Sore throat [ ] Ear pain |
| **Stomach** | [ ] Heartburn [ ] Nausea [ ] Vomiting [ ] Diarrhea [ ] Constipation [ ] Blood in stool |
| **Skin** | [ ] Rashes [ ] Moles [ ] Lumps [ ] Dryness [ ] Color changes |
| **Hormones** | [ ] Excess thirst [ ] Excess urination [ ] Heat/cold intolerance [ ] Diabetes |
| **Urinary** | [ ] Blood in urine [ ] Nighttime urination [ ] Frequency [ ] Burning |
| **Blood/Lymph** | [ ] Anemia [ ] Easy bruising [ ] Easy bleeding [ ] Swollen lymph nodes |
| **Eyes** | [ ] Double vision [ ] Mattering [ ] Itchiness [ ] Blurring [ ] Vision loss |
| **Heart** | [ ] Chest pain or pressure [ ] Forceful beats [ ] Irregular beat [ ] Murmur [ ] High BP |
| **Bones/Joints** | [ ] Joint pain [ ] Stiffness [ ] Swelling [ ] Muscle aches [ ] Gout |
| **Nerves** | [ ] Dizziness [ ] Fainting [ ] Seizures [ ] Tingling [ ] Weakness [ ] Tremors |
| **Allergies** | [ ] Medication allergy [ ] Dye allergy [ ] Seasonal allergy [ ] Food allergy [ ] Latex |
| **Lungs** | [ ] Dry cough [ ] Cough with blood [ ] Cough with mucus [ ] Wheezing [ ] Asthma |
| **Mental Health** | [ ] Depression [ ] Insomnia [ ] Panic [ ] Anxiety [ ] Memory issues |

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## Current Medication List

Patient Name: _____ Date of Birth: _____

*Please list all current medications, including prescriptions from other providers and over-the-counter products. List prescriptions first.*

### Medication Allergies

| Allergy | Reaction |
|---|---|
| | |
| | |

### Current Medications

| # | Medication Name | Dosage | Frequency | Start Date |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |
| 15 | | | | |

Reviewed by: _____ Date: _____ Initials: _____

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## Opioid Risk Assessment (ORT)

*Please check all that apply. This assessment helps us provide the safest care for you.*

### Family History of Substance Use

| | Yes | No |
|---|---|---|
| Family history of alcohol use disorder | [ ] (1 pt) | [ ] (0 pt) |
| Family history of illicit substance use | [ ] (1 pt) | [ ] (0 pt) |
| Family history of prescription medication misuse | [ ] (1 pt) | [ ] (0 pt) |

### Personal History of Substance Use

| | Yes | No |
|---|---|---|
| Personal history of alcohol use disorder | [ ] (1 pt) | [ ] (0 pt) |
| Personal history of illicit substance use | [ ] (1 pt) | [ ] (0 pt) |
| Personal history of prescription medication misuse | [ ] (1 pt) | [ ] (0 pt) |
| Age between 16-45 years | [ ] (1 pt) | [ ] (0 pt) |

### Psychological History

| | Yes | No |
|---|---|---|
| History of ADHD, OCD, bipolar disorder, or schizophrenia | [ ] (1 pt) | [ ] (0 pt) |
| History of depression | [ ] (1 pt) | [ ] (0 pt) |

**Total Score:** _____ Low Risk: 0-3 Moderate Risk: 4-7 High Risk: 8+

*Adapted from ORT-R by Cheatle, M., Compton, P., Dhingra, L., Wasser, T., O'Brien, C. (2019)*

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## Patient Information

### Patient Demographics

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____ Sex: [ ] M [ ] F

Language: _____ Ethnicity: _____

Employer: _____ Work Phone: _____

Referred by: _____

### Emergency Contact (someone NOT in your household)

Name: _____ Phone: _____

Relationship: _____

### Responsible Party (if different from patient)

Name: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

### Insurance Information

| | Primary Insurance | Secondary Insurance |
|---|---|---|
| Insurance Name: | _____ | _____ |
| Address: | _____ | _____ |
| City/State/ZIP: | _____ | _____ |
| Policy Holder: | _____ | _____ |
| Holder DOB: | _____ | _____ |
| SSN: | _____ | _____ |
| Group/Plan #: | _____ | _____ |
| Relationship: | [ ] Self [ ] Spouse [ ] Parent [ ] Child | [ ] Self [ ] Spouse [ ] Parent [ ] Child |

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## Authorization for Release of Medical Records

Patient Name: _____

Parent/Guardian (if minor): _____

I hereby authorize Skiatook Family Clinic to disclose health-related information from my (or my minor child's) medical records to the following individual or organization:

Name/Organization: _____

Address: _____

City/State/ZIP: _____

Information to be released:

[ ] Any and all medical records

[ ] Specific information (describe below):

_____

_____

_____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization expires on the date listed below, or if no date is specified, one year from the date of signature.

Expiration Date: _____ [ ] Do not expire this authorization

Patient/Guardian Signature: _____ Date: _____

Witness: _____

* Parent or Legal Guardian if patient is a minor.