DATE: _____

Patient's Last Name	First Name	Middle Name	Preferred Name	Maiden/Previous Name
Address	City		State	Zip
Date of Birth	Sex: Male ☐ Female ☐	Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐	Social Security #	
Home Phone	Cell Phone		E-Mail Address	
Employer's Name	Occupation		Business Phone	
Employer's Address	City		State	Zip
Spouse's Last Name	First Name		Phone	
Emergency Contact Name (other than spouse)	Phone Number		Relationship	
Who is your primary care physician (PCP)?	Were you referred to by a physician other than you PCP, if so who?			
What Pharmacy do you use? (Name, Phone Number, and Location)				
Are you in a skilled nursing home? If so, please list the name of the nursing home and contact phone number.				

Primary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			
Secondary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			
Tertiary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			

RESPONSIBILITY & RELEASE OF INFORMATION: I authorize payment of medical benefits for services rendered to USO. I understand that I am responsible to pay all medical services not covered by an authorization/agreement between my physician and insurance company employer. I authorize the release of all or part of the patient medical record for this period of care to any person or corporation liable for any part of the Physician charges. Oklahoma state law (63 O.S. 1-502.2 and 1-202.3) requires that we advise: "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficient Syndrome (AIDS)."
A PHOTOCOPY OF THE AUTHORIZATION AND ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENT OR AUTHORIZED SIGNATURE	RELATIONSHIP	DATE

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER	TREATING PHYSICIAN	By: