



**Oklahoma Interventional Infusion Center**  
9308 South Toledo, Tulsa, Oklahoma 74137  
Office: 918-728-8020 Fax 918-728-8019 Cell: 918-344-0807

## PATIENT REGISTRATION FORM

### PERSONAL INFORMATION

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

If by referral, who referred you? \_\_\_\_\_

### FINANCIAL INFORMATION

Financially Responsible Person's Name: \_\_\_\_\_

Financially Responsible Person's Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that the Oklahoma Interventional Infusion Center does not accept insurance. Upon request, I will be given a receipt that I may submit to insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment (unless an emergency) I will be billed a \$100 fee. I have been given the opportunity to ask questions regarding this statement.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Initial: \_\_\_\_\_



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## HEALTH INFORMATION

Medication Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking MAOI Inhibitors? ☐ Y ☐ N Are you currently taking Benzodiazepines? ☐ Y ☐ N

I am currently compliant with all medications prescribed by my mental health provider ☐ Y ☐ N If no, please explain:

\_\_\_\_\_

\_\_\_\_\_

Current Mental Health Provider(s) if applicable:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Provider:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Current and previous psychiatric diagnosis or pain diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What treatments/medications have you tried for your condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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History of Surgical Procedures:


Any problems with anesthesia? If so, please describe: \_\_\_\_\_

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Health History:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Respiratory	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Sleep apnea <input type="checkbox"/> CPAP	<input type="checkbox"/> Recent cough or cold
<input type="checkbox"/> COPD / Emphysema	<input type="checkbox"/> Home oxygen
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Difficulty lying flat
<input type="checkbox"/> Tobacco use      Packs/per day	Number of years smoked

Cardiovascular	
<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heart attack
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Valvular disease
<input type="checkbox"/> Dysrhythmia / Irregular heartbeat	<input type="checkbox"/> Murmur
<input type="checkbox"/> Anemia	<input type="checkbox"/> Edema

Gastrointestinal	
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hiatal hernia/ reflux
<input type="checkbox"/> Liver disease / Cirrhosis	<input type="checkbox"/> Nausea & vomiting
<input type="checkbox"/> Hepatitis / Jaundice	<input type="checkbox"/> Bowel obstruction
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Irritable bowel syndrome

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Neurological / Musculoskeletal	
<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Seizures
<input type="checkbox"/> Concussion / Traumatic brain injury	<input type="checkbox"/> Dementia
<input type="checkbox"/> Brain aneurysm	<input type="checkbox"/> Brain surgery
<input type="checkbox"/> Migraines	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Neuromuscular disease
<input type="checkbox"/> Paresthesias / Neuropathy	<input type="checkbox"/> Muscle weakness / Paralysis
<input type="checkbox"/> Back pain	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anti-anxiety medication
<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar depression
<input type="checkbox"/> Post-traumatic stress disorder	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Hallucinations / Delusions
<input type="checkbox"/> History of violent behavior	

Renal / Endocrine	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Adrenal insufficiency
<input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> Interstitial bladder disease
<input type="checkbox"/> Renal insufficiency	<input type="checkbox"/> Renal failure
<input type="checkbox"/> Dialysis	

Other	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lupus
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Other autoimmune
<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> Steroid use
<input type="checkbox"/> Obesity	<input type="checkbox"/> Sickle cell disease / Trait
<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Infectious disease	
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Opioid use
<input type="checkbox"/> Marijuana use	<input type="checkbox"/> Alcohol use # Drinks per Week
<input type="checkbox"/> Illicit drug use	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> History of suicidal attempts
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Breastfeeding

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Practice Policies**

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

**INITIAL INTERVIEW:** Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:

- a) If ketamine is an appropriate treatment option.
- b) Frequency of ketamine infusion sessions.
- c) Goals of therapy (what you hope to gain from this process.)

**APPOINTMENTS:** Each appointment varies in length depending on your chief complaint. Typically, 40 min infusion appointments take just under 2 hours, 4 hour infusions for chronic pain are typically around 5 hours in length. At the end of each appointment you can make arrangement for your next appointment or you may also book all your prescribed appointments at once.

**CANCELLATIONS:** If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged a \$100 fee for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

**PAYMENTS:** Payment in full for each appointment is expected prior to the start of your appointment. We will accept credit, cash and check. Please make checks out to Oklahoma Interventional Infusion Center or OIIC.

**INSURANCE:** Insurance is an agreement between you and how treatment will be paid for is decided by your insurance company. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with any insurance plans. However, we will assist you in by giving you receipts to submit, and follow up contacts. Some insurance companies will pay for a portion of outpatient ketamine infusion services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. Payments for services received through The Oklahoma Interventional Infusion Center are ultimately your responsibility. If your insurance company requires that outpatient ketamine infusion services be preauthorized, it is your responsibility to initiate the authorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

**CONFIDENTIALITY:** All information regarding the specific nature of your treatment is maintained at the Oklahoma Interventional Infusion Center and is considered confidential within the office unless specified by you in writing. However, each provider at this office reserves the right to use specialty consultation with other medical providers at the office as deemed necessary. We follow HIPAA and maintain confidentiality.

Please initial below.

\_\_\_\_\_ I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

\_\_\_\_\_ I have received a copy of the Privacy Practices Form.

Patient Name: \_\_\_\_\_ Initial: \_\_\_\_\_



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Please check yes or no, if yes please give necessary contact information of physician:

☐ Yes ☐ No I consent to the exchange of treatment information between the and the Oklahoma Interventional Infusion Center my primary care and / or mental health provider.

Physician's Name/Office and Phone Number: \_\_\_\_\_

\_\_\_\_\_

Physician's Name/Office and Phone Number: \_\_\_\_\_

\_\_\_\_\_

Physician's Name/Office and Phone Number: \_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Initial: \_\_\_\_\_