OKLAHOMA State Department of Health

Know Your Numbers- Preventive Health Screening

Section 1: Participant Information & Consent *(client to complete)*

Last Name	First Name	Middle Initial	Suffix (eg., Jr, III)	Age†	Date of Birth

Street Address	City	State	Zip

Phone Number ☐ Cell ☐ Home ( )	Gender ☐ Female ☐ Male ☐ Other	Hispanic? ☐ Yes ☐ No	Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other	Email

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown	Primary Language ☐ English ☐ Spanish ☐ American Sign Language ☐ Other

State of Birth	Country of Birth	May we contact you? ☐Yes, at address provided ☐Yes, at phone provided ☐Yes, at email provided ☐ No

If the client is under 18 years of age, please complete guardian information.
Guardian Relationship to Client: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other **Guardian Name (Last, First)**____________________________________

Medical Insurance Information

Does client have health insurance? ☐ Yes ☐ No If yes, please provide insurance information below.

Please provide the following information: **Annual Household Income $** ____________________**Number of people supported by income**________________

☐ **SoonerCare/ Medicaid**	SoonerCare/Medicaid Number	Member First and Last name as it appears on policy or card		Mother's Maiden Name	
☐ **Private Insurance**	Primary Insurance Co & EDI/Payer ID	Policyholder	Member Name Relation to Policyholder:	Member ID	Group Number
	Secondary Insurance Co & EDI/Payer ID	Policyholder	Member Name: Relation to Policyholder:	Member ID	Group Number
☐ **Medicare**	Do you have Medicare Part B? ☐ Yes ☐ No	Is Medicare Primary? ☐ Yes ☐ No		Medicare Number	

Consent

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health (OSDH) and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions. I also understand that:

- The information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management, and billing purposes.
- I will not be denied service because of my inability to pay.
- I may refuse service at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: It is ultimately the client's responsibility to know your coverage and benefits. You may be responsible for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you may be responsible for your balance in full.

- I authorize the OSDH to furnish information to my insurance carrier(s) concerning my care.
- I authorize my insurer(s) to pay any benefits directly to OSDH. I understand that any amount remaining after such payment has been made by my insurance carrier becomes my responsibility.
- I have read the above policy regarding my financial responsibility to OSDH for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate.
- I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Statement as required by the Health Information Portability and Accountability Act (HIPAA). I can also find a copy on the agency website.

Client/Guardian Signature: ____ Date: ________________

Oklahoma State Department of Health

Know Your Numbers- Preventive Health Screening

Section 2: Results *(Office Use Only)*			
Date of Service:	**CHD- Mobile Unit:**	Is client fasting? ☐ Yes ☐ No	Pre-screening completed? ☐ Yes ☐ No

Body Measurements & Blood Pressure		**Blood Screening Results**	
Blood Pressure	___ ___ ___ / ___ ___ ___ mmHG	**Total Cholesterol**	mg/dL
Height (w/o shoes)	___ ___. ___ total inches (_____ Ft. ______ In.)	**HDL Cholesterol**	mg/dL
Weight (w/o shoes)	____ ____ ____. ____ pounds	**Blood Glucose**	mg/dL
BMI (Body Mass Index)	____ ____. ____ kg/m^2	**TC/HDL Ratio**	_____._____
Other:			
Other:			

Referral ☐ No ☐ Yes *(Record Opened and ODH 399 completed)* ☐ Blood Screening Deferred (due to positive pre-screening)

Notes: ____

____

____

____

____

____

____ ____________________

Provider Signature/Credentials Date