

Patient Intake Form

\$35 Dr. Fee + \$1.50 Credit/Debit Card Fee.

State fee of \$104.30 OR \$22.50 (with proof of Medicare, Medicaid, Sooner Care, or 100% Disabled Vet)

*DISCLAIMER: This form must be filled out to COMPLETION. Information provided on this form is REQUIRED for your OMMA application. A Better Bloom Health and Wellness DOES NOT KEEP PATIENT INFORMATION after application submission.

DATE ___/___/___ SITE LOCATION _____ OR FACEBOOK _____

Check ONE New Patient _____ or Renewal _____ If RENEWAL write license expiration date ___/___/___

DRIVERS LICENSE / STATE ID INFORMATION:

NAME (How it appears on your license) First _____ MI _____ Last _____

DATE OF BIRTH ___/___/___ DRIVERS LICENSE, STATE ID, OR PASSPORT NUMBER _____

STREET ADDRESS (AS IT APPEARS ON LICENSE) _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

DRIVERS LICENSE, STATE ID, OR PASSPORT EXPIRATION DATE ___/___/___

MAILING INFORMATION:

Check ONE My mailing address is the same as my ID _____ My mailing address is different from my ID _____

MAILING ADDRESS (If different from ID) _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

OMMA INFORMATION:

If you are **NOT** registered with OMMA check **HERE** _____

EMAIL _____

PASSWORD _____

CONTACT INFORMATION (This MUST be valid):

PHONE NUMBER _____ CELL PHONE NUMBER _____

EMAIL _____

PAYMENT INFORMATION (Note: We do NOT accept American Express!!):

CIRCLE ONE: DEBIT CARD | CREDIT CARD | PRE-PAID CARD

CARD NUMBER: _____

EXPIRATION DATE: ___/___/___ CVV COVE: _____ ZIP CODE: _____

NAME ON CARD: _____

INSURANCE INFORMATION CHECK IF APPLIES:

Note: Proof of Medicaid, Medicare, or Sooner Care must be presented at time of appointment. Valid proof must be documentation issued by the Oklahoma Health Care Authority such as a physical card, paper card, or a screenshot of your online account!!!!

MEDICARE _____ MEDICAID _____ SOONER CARE _____

Office Number: 405.341.2050