

NEW PATIENT SCHEDULING DEMOGRAPHICS

ALL INFORMATION IS **REQUIRED** FOR SCHEDULING APPOINTMENTS. PLEASE COMPLETE BOTH SIDES OF THE FORM

SELECT ONE PREFERRED PCP BELOW:

Accepting New Patients Now:

Not Accepting New Patients At This Time:

Monticello - ___ Narain Mandhan, MD / Crickett Engelbrecht, FNP-C
 ___ Evelyn Huang, MD / Jennifer Oyler, PA-C
 ___ Lauren Fore, MD / Cydney Longley, FNP
 ___ Alina Paul, MD
 ___ Tia Fitzpatrick-Butler, NP
 ___ Lauren Coover, PA-C
 ___ David Liss, FNP
Atwood ___ Danielle Pare, FNP

Brian Yocks, MD
 Andrea Tirpak, APN, FNP-BC
 Jamey Witmer, FNP
Cerro Gordo

LAST NAME _____ FIRST NAME _____ MIDDLE INIT _____

OTHER NAME KNOWN BY: _____

ADDRESS _____ PO BOX (IF APPLICABLE) _____

CITY _____ STATE _____ ZIP CODE _____

DOB _____ SS# _____ GENDER: ___ Male ___ Female

LANGUAGE SPOKEN _____ RACE _____ ETHNICITY: ___ Non-Hispanic ___ Hispanic

MARITAL STATUS _____ RELIGION _____

PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK

SECONDARY PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK

EMAIL _____

PREFERRED METHOD OF CONTACT:

- ☐ CALL ☐ EMAIL
☐ TEXT ☐ WRITTEN

PATIENT'S EMPLOYER _____

ADDRESS _____ PHONE _____

OCCUPATION _____ STATUS (FT, PT, PRN) _____

GUARANTOR (IF PATIENT IS UNDER 18) _____

ADDRESS _____

PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK ___ OTHER

DOB _____ SS# _____

CONTINUED ON BACK

INSURANCE CO - PRIMARY* _____ MEMBER ID # _____ GROUP # _____

*SUBSCRIBER INFORMATION (IF NOT PATIENT):

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ADDRESS _____

SUBSCRIBER PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK ___ OTHER

SUBSCRIBER DOB _____ SUBSCRIBER SS# _____

INSURANCE CO -SECONDARY* _____ MEMBER ID # _____ GROUP # _____

*SUBSCRIBER INFORMATION (IF NOT PATIENT):

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ADDRESS _____

SUBSCRIBER PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK ___ OTHER

SUBSCRIBER DOB _____ SUBSCRIBER SS# _____

CONTACT INFORMATION (OTHER THAN THE PATIENT):

PRIMARY CONTACT

LAST NAME _____

FIRST NAME _____

RELATIONSHIP _____

PHONE # _____

COMPLETE ADDRESS _____

SECONDARY CONTACT

LAST NAME _____

FIRST NAME _____

RELATIONSHIP _____

PHONE # _____

COMPLETE ADDRESS _____

07/30/26

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Mailing Address of Patient: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Last 4 digits of SSN: _____ MRN: _____

 I authorize: ☐ Kirby Medical Group - Clinic Provider: _____ ☐ Kirby Medical Center - Hospital

☐ To Release to: _____
 (Name of Health Care Facility, Individual, or Agency, etc.)

☒ To Request from: _____
 (Address)

(City, State, Zip) (Phone) (Fax)

 Method of Release: ☐ Mail Pick up at: ☐ HIM Department ☐ Emergency Dept. Registration ☒ Fax
☐ Email to Patient Service Provided by Verisma Email Address: _____ 217-762-1702

SPECIFIC RECORDS TO BE RELEASED:

CLINIC Dates: _____ to _____	HOSPITAL Dates: _____ to _____
☐ Record Abstract (last 2 years) ☐ Immunization Record ☐ Mental Health (requires additional authorization form) ☐ Other _____ ☐ Provider Notes	☐ ED Visit(s) ☐ Inpatient Hospitalization ☐ Immunization Record ☐ Abstract - H&P, Disc Sum, Progress Notes ☐ Laboratory Report(s) ☐ Complete Stay ☐ Pathology ☐ Operative Report(s) ☐ Radiology ☐ Therapy Services ☐ Reports ☐ CD Images ☐ Other _____

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including alcohol/drug abuse treatment) ☐ HIV-related (HIV/AIDS-related testing) & communicable disease(s) information
☐ Genetic Information ☐ Child Abuse/Neglect ☐ Abuse of Adult with a Disability ☐ Sexual Assault Treatment

☒ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

 The purpose of this disclosure of information is _____
 (i.e., continuing care, insurance claim, legal counsel, etc.)

A separate special authorization must be completed to release mental health records.

- * I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- * I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
- * I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
- * This authorization will expire on the following date or event: _____. If I do not specify an expiration date or event, this authorization will expire in one year.
- * I understand that I am entitled to a copy of this authorization.
- * I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- * If the patient is 18 years of age or older, the patient must sign and date the form.
- * If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
 - ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

- * If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
 - ☐ Parent ☐ Legal Guardian

 Signature: X Date Signed: X

Printed Name of Person Signing (if not patient): _____ Phone #: _____

STAFF USE ONLY
Reason for Verbal:

 Verbal Authorization Given By: _____ Verbal Obtained by Staff Name: _____ ☐ PHE ☐ Other: _____
 Name Relationship to Patient

Records Given to Patient by Staff Name: _____ Type of ID Verified: _____ Date: _____

☐ HIM ☐ Registration ☐ Clinic

AUTH TO RELEASE PHI

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HEALTH HISTORY QUESTIONNAIRE

Adult ≥12

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (Last, First, M.I.):		DOB:
☐ Male ☐ Female ☐ _____		
Previous or referring doctor:		Date of last physical exam:
Language spoken at home:		

PERSONAL HEALTH HISTORY

Would you like information on vaccines that are recommended for you? ☐ Yes ☐ No

List any medical problems that other doctors have diagnosed:

Diagnosis	Diagnosis	Diagnosis

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Specialists

What specialists do you see?

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CENTER

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Name of Drug	Strength/Frequency Taken	Reason for Medication

Allergies to Medications

Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE
OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise
	☐ Occasional vigorous exercise
	☐ Regular vigorous exercise
Diet	Are you on a special diet? ☐ Yes ☐ No
	If yes, what and why?
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola ☐ Other:
	# of cups/cans per day?

FAMILY HEALTH HISTORY

Diseases	Mother	Father	Siblings	Grandmother	Grandfather	Child
Hypertension	☐	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer (type)						
Osteoporosis	☐	☐	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐	☐	☐
Alcoholism/Drug Abuse	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐
Emphysema/COPD	☐	☐	☐	☐	☐	☐
Liver failure/Cirrhosis	☐	☐	☐	☐	☐	☐
Kidney failure/Dialysis	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

MENTAL HEALTH

Do you have concerns for your mental health?		☐ Yes ☐ No
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	
	If yes, what kind?	
	How many drinks per week?	
	Are you concerned about the amount you drink? ☐ Yes ☐ No	
Tobacco	Do you use tobacco? ☐ Yes ☐ No	
	☐ Cigarettes - pks/day ☐ Chew - #/day ☐ Pipe - #/day ☐ Pouches - #/day	
	☐ # of years ☐ Or year quit ☐ Cigars - #/day ☐ Vapes - #/day	
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No	
	Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No	
	Do you currently use THC? ☐ Yes ☐ No	

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WOMEN'S HEALTHHeavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Date of last Pap?

Date of last mammogram, if applicable:

Date of last colonoscopy, if applicable:

Date of last bone density, if applicable:

MEN'S HEALTH

Has the force of your urination decreased?

Date of last colonoscopy, if applicable:

HEALTH GOALS

Please list your top health goals and any factors preventing you from achieving those goals.

☐ Goal: ☐ Preventing Factors:☐ Goal: ☐ Preventing Factors:☐ Goal: ☐ Preventing Factors**OTHER**

Any concerns that you would like to discuss?

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Dear Patient,

We at Kirby Medical Group want to ensure we are fully successful in providing the care you deserve, in the setting which is most appropriate, while being financially responsible as a Medical Home. Please take a few minutes to answer the following questions and complete the checklist so that we can help guarantee that success. We are dedicated to our patients and want to help you reach your healthcare goals. Thank you for choosing Kirby Medical Group as your Patient-Centered Medical Home.

NEW PATIENT CHECKLIST

- ☐ I have completed the Release of Records form or I have retrieved my health records and submitted to Kirby Medical Group. These include any screening records (colonoscopies, mammograms, lab work), vaccination records (if the patient is a child), medication lists, pharmacy records, surgical history, specialist visits (cardiology, pulmonology, rheumatology, etc.), or other pertinent history.
- ☐ I actively participated in choosing my provider at Kirby Medical Group, a provider was not assigned to me.
- ☐ I have submitted my up-to-date insurance information. If you do not have insurance, please see someone at the desk to obtain information on how we can help you find an insurance payor.
- ☐ I have been given information on Kirby Medical Group's No-Show and Appointment Cancellation Policies.
- ☐ I have been given information on Artera, Kirby Medical Group's automated appointment reminder service and electronic communication portal.
- ☐ I have received a copy of information on the services we provide at each Kirby Medical Group location and services available at Kirby Medical Center.

Patient Signature

Date

Thank you for taking the time to complete this information. If you have any questions, please see the front desk or you may contact Kirby Medical Group's clinic director, Ryan Hastings, at (217) 762-6241.