

NEW PATIENT SCHEDULING DEMOGRAPHICS
ALL INFORMATION IS **REQUIRED** FOR SCHEDULING APPOINTMENTS. PLEASE COMPLETE **ENTIRE** FORM

SELECT ONE PREFERRED PCP BELOW:

Monticello - ☐ Narain Mandhan, MD ☐ Evelyn Huang, MD ☐ Lauren Fore, MD
☐ Lauren Coovert, PA-C ☐ David Liss, FNP ☐ Crickett Engelbrecht, FNP-C

Atwood - ☐ Tara Shutt, FNP-BC ☐ Jamey Witmer, NP

Cerro Gordo - ☐ Andrea Tirpak, APN, FNP-BC ☐ Jamey Witmer, NP

LAST NAME _____ FIRST NAME _____ MIDDLE INIT _____

OTHER NAME KNOWN BY: _____

ADDRESS _____ PO BOX (IF APPLICABLE) _____

CITY _____ STATE _____ ZIP CODE _____

DOB _____ SS# _____

LANGUAGE SPOKEN _____ RACE _____ ETHNICITY _____ RELIGION _____

PHONE # _____ TYPE: ☐ HOME ☐ CELL ☐ WORK

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

EMAIL _____

EMPLOYER _____

ADDRESS _____ PHONE _____

OCCUPATION _____ STATUS (FT, PT, PRN) _____

INSURANCE-PRIMARY _____ MEMBER ID # _____ GROUP # _____

SUBSCRIBER (IF NOT SELF) _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

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

DOB _____ SS# _____

INSURANCE-SECONDARY _____ MEMBER ID # _____ GROUP # _____

SUBSCRIBER (IF NOT SELF) _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

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

DOB _____ SS# _____

CONTINUED ON BACK

GUARANTOR (IF PATIENT IS UNDER 18) _____

ADDRESS _____

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

DOB _____ SS# _____

CONTACT INFORMATION:

PRIMARY CONTACT

LAST NAME _____

FIRST NAME _____

RELATIONSHIP _____

PHONE # _____

FULL ADDRESS _____

SECONDARY CONTACT

LAST NAME _____

FIRST NAME _____

RELATIONSHIP _____

PHONE # _____

FULL ADDRESS _____

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
1000 Medical Center Dr., Monticello, IL 61856

☐ 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 in Person at: ☐ HIM Department ☐ Emergency Dept. Registration ☐ Fax to 217-762-1702
☐ E-mail Service Provided by ScanSTAT E-mail Address: _____

SPECIFIC RECORDS TO BE RELEASED:

Clinic	Dates: _____ to _____	Hospital	Dates: _____ to _____
<input type="checkbox"/> Record Abstract (last 2 years) <input type="checkbox"/> Immunization Record <input type="checkbox"/> Mental Health (requires additional authorization form) <input type="checkbox"/> Other _____ <input type="checkbox"/> Provider Notes		<input type="checkbox"/> ED Visit(s) <input type="checkbox"/> Immunization Record <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> Pathology <input type="checkbox"/> Radiology <input type="checkbox"/> Reports <input type="checkbox"/> CD Images	<input type="checkbox"/> Inpatient Hospitalization <input type="checkbox"/> Abstract – H&P, Disc Sum, Progress Notes <input type="checkbox"/> Complete Stay <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Therapy Services <input type="checkbox"/> Other _____

I specifically authorize the release of information relating to:

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

X _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

The purpose of this disclosure of information is _____ continuing care
(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: _____

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

STAFF USE ONLY

Verbal Authorization Given By: _____ Verbal Obtained by Staff Name: _____ Reason for Verbal: ☐ PHE ☐ Other: _____
Name Relationship to Patient
Records Given to Patient by Staff Name: _____ Type of ID Verified _____ Date: _____
☐ HIM ☐ Registration ☐ Clinic

HEALTH HISTORY QUESTIONNAIRE

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

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	
Language spoken at home:		

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio
Immunizations and dates (if known):	<input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza <input type="checkbox"/> MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed

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Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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KIRBY MEDICAL
CENTER

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Have you ever had blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug	Strength	Frequency Taken

Allergies to medications	
Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY
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ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.
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Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat on an average day?				
	Rank salt intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low	
	Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
# of cups/cans per day?					

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Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pks/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used?			
	Any discomfort with intercourse?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

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FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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WOMEN ONLY

Date of onset of menstruation: _____		
Date of last menstruation: _____		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam? _____		
Date of last mammogram, if applicable: _____		
Date of last colonoscopy, if applicable: _____		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning during discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last colonoscopy, if applicable: _____		

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OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy Levels
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

HEALTH GOALS

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

<input type="checkbox"/> Goal:	<input type="checkbox"/> Preventing Factors:
<input type="checkbox"/> Goal:	<input type="checkbox"/> Preventing Factors:
<input type="checkbox"/> Goal:	<input type="checkbox"/> Preventing Factors:

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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.

How often do you seek care in an Emergency Department?	<input type="checkbox"/> Less than once a year	<input type="checkbox"/> 2-3 times a year	<input type="checkbox"/> 3-5 times a year	<input type="checkbox"/> More frequently than 5 times a year
How often are you hospitalized for chronic illness? Leave blank if not applicable.	<input type="checkbox"/> Less than once a year	<input type="checkbox"/> 2-3 times a year	<input type="checkbox"/> 3-5 times a year	<input type="checkbox"/> More frequently than 5 times a year
Do you see any specialists for any diseases or chronic illnesses?	<input type="checkbox"/> Yes, please list:			
How many medications do you take on a daily basis:	<input type="checkbox"/> 0-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5-7	<input type="checkbox"/> More than 7
Do you use any social or community services to help you meet your healthcare needs? Leave blank if not applicable.	<input type="checkbox"/> Yes, please list:			

NEW PATIENT CHECKLIST

<input type="checkbox"/> 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.
<input type="checkbox"/> I actively participated in choosing my provider at Kirby Medical Group, a provider was not assigned to me.
<input type="checkbox"/> 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.
<input type="checkbox"/> I have been given information on Kirby Medical Group's No-Show and Appointment Cancellation Policies.
<input type="checkbox"/> I have been given information on Solution Reach, Kirby Medical Group's automated appointment reminder service and electronic communication portal.
<input type="checkbox"/> 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.

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, Sara Wells, at (217) 762-1701.

* Patient Signature

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Save

Complete

Date

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