

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
\_\_\_ Tia Fitzpatrick-Butler, NP
\_\_\_ Lauren Fore, MD / Cydney Longley, FNP
\_\_\_ Alina Paul, MD
\_\_\_ David Liss, FNP
Atwood \_\_\_ Danielle Pare, FNP
Cerro Gordo \_\_\_ Jamey Witmer, FNP

Evelyn Huang, MD
Glen Dust, MD
Brian Yocks, MD
Lauren Coovert, PA-C
Tara Shutt, FNP-BC
Andrea Tirpak, APN, FNP-BC

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

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-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-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 PATIENT):**

**PRIMARY CONTACT**

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

PHONE # \_\_\_\_\_

COMPLETE ADDRESS \_\_\_\_\_

\_\_\_\_\_

**SECONDARY CONTACT**

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

PHONE # \_\_\_\_\_

COMPLETE 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	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	Dates: _____ to _____ <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

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## HEALTH HISTORY QUESTIONNAIRE

### Pediatric 0 - 11

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

<b>Name (Last, First, M.I.):</b> _____	<b>DOB:</b> _____
<b>Birth Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Gender Identity:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	
<b>Previous or referring doctor:</b> _____	<b>Date of last physical exam:</b> _____
<b>Language spoken at home:</b> _____	

### PERSONAL HEALTH HISTORY

**Up to date with childhood vaccines?**    Yes    No   Why? \_\_\_\_\_

**Immunizations and dates (if known):**

COVID

HPV

Influenza

#### List any medical problems that other doctors have diagnosed:

ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/Other <input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Delay <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Lead Poisoning <input type="checkbox"/> Yes <input type="checkbox"/> No	Strep Throat (recurrent) <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No	UTI <input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Delay <input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No	Varicella (chickenpox) <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No	Otitis Media <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____
Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No		_____

#### Birth History: Please complete for patients currently under 1 year of age.

Birth Length: _____	Birth Weight: _____	Birth Head Circ: _____
Discharge Weight: _____	Gestational Age: _____	Delivery Method: Vaginal / C-section
Duration of Labor: _____	Hospital Name: _____	
APGAR Score (1 min): _____	APGAR Score (5 min): _____	Feeding: Breast / Formula

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**Surgeries**

Year	Reason	Hospital

**Other hospitalizations**

Year	Reason	Hospital

**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

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## FAMILY HEALTH HISTORY

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

Do you have any concerns about mental health?     Yes     No

## 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: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

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## 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:

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:			

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## 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 Solution Reach, 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.

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Save

Complete