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 ___ Glen Dust, MD ___ Crickett Engelbrecht, FNP-C David Liss, FNP ___ Lauren Coovert, PA-C Tara Shutt, FNP-BC ____ Jamey Witmer, NP Atwood -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) _____ _____STATE____ZIP CODE_____ DOB _____SS# LANGUAGE SPOKEN ______RACE _____ETHNICITY _____ RELIGION _____TYPE: HOME CELL WORK SECONDARY PHONE #_____TYPE: ___ HOME ___ CELL ___WORK PREFERRED METHOD OF CONTACT: □ CALL □ EMAIL ☐ TEXT ☐ WRITTEN **EMAIL 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 #		GRO	UP#	
*SUBSCRIBER INFORMATION (IF NOT PATIENT):					
SUBSCRIBER NAME	RELAT	TIONSHIP TO F	PATIENT		
SUBSCRIBER ADDRESS					
SUBSCRIBER PHONE #	TYPE:	HOME _	CELL	work _	OTHER
SUBSCRIBER DOB	SUBSCRIBER SS#	-			
INSURANCE-SECONDARY*	MEMBER ID #		GRO	UP#	
*SUBSCRIBER INFORMATION (IF NOT PATIENT):					
SUBSCRIBER NAME	RELAT	TIONSHIP TO I	PATIENT		
SUBSCRIBER ADDRESS					
SUBSCRIBER PHONE #	TYPE:	HOME _	CELL _	work _	OTHER
SUBSCRIBER DOB	SUBSCRIBER SS#	8- <u></u>			
CONTACT INFORMATION (OTHER THAN I	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

'atient Name:	566		Date of Birth:	
failing Address of Patient:_		City:	State:	Zip:
hone Number:		Last 4 digits of SSN:	MRN:	
authorize: ☒ Kirb 100 ☐ To Release to:	y Medical Group- Clinic Provid 0 Medical Center Dr., Monticello, IL 56	der:	☐ Kirby Medical C	enter - Hospital
i To Nelease to.	(Name of Health Care Facility, Individ	dual, or Agency, etc.)		
To Dogwoot from:	· ·			
To Request from:	(Address)			
	(City, State, Zip)	(Phone)	(Fax)	
lethod of Release:		: HIM Department Em	이번 큐일에 되면 된다. 이번 전혀 경기에 없고 큐일이 가지지 때 없다.	
PECIFIC RECORDS TO BE	E-mail Service Provided by ScanSTAT	E-mail Address:		217-702-1
Clinic Dates:	to	Hospital Dates:	to	
		Treophia Balco.		
Record Abstract (las		☐ ED Visit(s) ☐ Immunization Record	☐ Inpatient Hospita	lization P. Disc Sum, Progress Notes
☐ Immunization Record		☐ Laboratory Report(s)	☐ Complete Stay	- A () - () 이 경기에 가지하는 위험에서 그 이 경우를 하는 것이 되었다. () 전쟁을 다 되었다.
☐ Mental Health (<mark>requir</mark> ☐ Other	es additional authorization form)	☐ Pathology	☐ Operative Report	t(s)
Provider Notes		Radiology	☐ Therapy Service	
		☐ Reports ☐ CD Images	Other	
alfiaelle				
	elease of information relating to:			
	g alcohol/drug abuse treatment) ☐ HIN☐ Child Abuse/Neglect ☐	V-related information (HIV/AIDS-related information (HIV/AIDS-rela		
-amatic Information				Ireatment
senetic Information	☐ Child Abuse/Neglect ☐	Abuse of Adult with a Disability	□ Sexual Assault	Treatment
	DR PERSONAL REPRESENTATIVE	DATE	—— Sexual Assault	Trouble to the state of the sta
GNATURE OF PATIENT C	DR PERSONAL REPRESENTATIVE	DATE	—— Sexual Assault	· · · · · · · · · · · · · · · · · · ·
GNATURE OF PATIENT C	DR PERSONAL REPRESENTATIVE	DATE		
GNATURE OF PATIENT C	DR PERSONAL REPRESENTATIVE	DATE re (i.e., continuing care, insurance claim, I		
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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.

Name (Last, First, M.	l.):			DOB:		
Birth Gender: 🗅 Ma	ale 🗅 Female	Gender ider	ntity: 🗅 Male	□ Female □		
Previous or referrin	g doctor:		Date	of last physical exam	:	
Language spoken a	at home:					
		PERSONAL HE	ALTH HISTOR	Υ		
Up to date with chil	dhood vaccine	s? 🗆 Yes 🗅 N	Nc Why?			
Immunizations and	COVID	= ====				
dates (if known):	☐ HPV					
	□ Influenza					
List any medical pr	oblems that oth	ner doctors have	diagnosed:			
ADD/ADHD	☐ Yes ☐ No	Headaches/Other	☐ Yes ☐ No	Scoliosis	☐ Yes	□ No
Allergies	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Seizures	☐ Yes	□ No
Asthma	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No	Sickle Cell Anemia	☐ Yes	□ No
Behavioral Problems	☐ Yes ☐ No	Jaundice	🗋 Yes 📋 No	Speech Delay	☐ Yes	□ No
Cancer	☐ Yes ☐ No	Lead Poisoning	🗋 Yes 🗋 No	Strep Throat (recurrent)	☐ Yes	□ No
Chronic Encephalopathy	☐ Yes ☐ No	Meningitis	🗋 Yes 🗋 No	υτι	☐ Yes	□ No
Developmental Delay	☐ Yes ☐ No	Obesity	🗋 Yes 📋 No	Varicella (chickenpox)	☐ Yes	□ No
Diabetes Mellitus	☐ Yes ☐ No	Otitis Media	☐ Yes ☐ No	Vision Problems	☐ Yes	□ No
Eczema	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Other:		
Headaches/Migraines	☐ Yes ☐ No					
Birth History: Plea	se complete fo	r patients curren	tly under 1 yea	r of age.		
Birth Length:		Birth Weight: _		Birth Head Circ:		- 01
Discharge Weight:		Gestational Age: _		Delivery Method: Vagir	nal / C-sec	ction
Duration of Labor:		Hospital Name: _				
APGAR Score (1 min): _		APGAR Score (5 r	min):	Feeding: Breast / Form	nula	





Surge	ries			
Year	Reason		F	Hospital
Other I	nospitalizations			
Year	Reason		F	Hospital
List you	ur prescribed drugs	s and over-the-counter dru	gs, such a	as vitamins and inhalers:
Name o	of Drug	Strength		Frequency Taken
	es to Medications			
Name o	f Drug	Reaction You Had		

Previous Page

HEALTH HABITS AND PERSONAL SAFETY

	ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL
Diet	Are you on a special diet?
	If yes, are you on a physician prescribed medical diet? □ Yes □ No
	# of meals you eat on an average day?
	Rank salt intake 🗅 High 🗅 Medium 🗅 Low
	Rank fat intake 🗅 High 🗅 Medium 🗅 Low
	Rank sugar intake 🗆 High 🗅 Mediun 🗅 Low
	□ Juice □ Tea □ Cola # of cups/cans per day?
Dental Hygiene	□ Been to dentist □ Brush teeth regularly
	Last appt:
Secondhand Smoke Exposure?	□ Yes □ No
Safety & Environ- mental Exposures	Smoke Exposure Location: Yes No Yes No Pets: Yes No Yes No Mold/Mildew: Yes No Yes No Lead Paint: Yes No Who smokes: Yes No Yes No Carpets: Yes No Pests/Rodents: Yes No
Day Care Education Employment	Type of Day Care (check all that apply): _ Family Member/Relative/Friend _ Child Care Center (commercial) _ Prekindergarten _ Head Start _ Preschool _ Early Intervention _ Home Child Care Provider (day care in someone's home)

Previous Page

	AGE	SIGNIFICANT HEALTH PROBLEMS	3	AGE	SIGNIFICANT HEALTH PROBLE	
Father			Grandmother Maternal			
Mother			Grandmother Paternal			
Sibling	□ M □ F		Grandfather Maternal			
	□ M □ F		Grandfather Paternal			
	□ M □ F					
	□ M □ F					
	□ M □ F					
	□ M □ F					
o you ha	ave any c	concerns about mental health?	□ Yes □ No			
		ОТНЕ	R PROBLEMS			
Check if	you have	, or have had, any symptoms in	the following areas t	o a signi	ficant degree and briefly expla	
Skin		□ Chest/Hea	rt		☐ Recent changes in:	
□ Head	d/Neck	□ Back			□ Weight	
□ Ears		□ Intestinal	□ Intestinal		□ Energy Levels	
□ Nose		□ Bladder	□ Bladder		□ Ability to sleep	
		□ Bowel	Adul Language		☐ Other pain/discomfort:	
		□ Circulation	culation			

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	HE	ALTH GOALS		
Please list your top health	goals and any factors p	reventing you from	achieving those go	oals.
□ Goal:	□ Preventing	g Factors:		
□ Goal:	□ Preventing	g Factors:		
□ Goal:	□ Preventing	g Factors		
Dear Patient, We at Kirby Medical of the setting which is most a few minutes to answer that success. We are decayou for choosing Kirby Medical Success.	the following questions dicated to our patients a	g financially respon and complete the c and want to help you	sible as a Medical hecklist so that we I reach your health	Home. Please take can help guarantee
How often do you seek care in an Emergency Department?	Less than once a year	2-3 times a year	3-5 times a year	More frequently than 5 times a year
How often are you hospitalized for chronic illness? Leave blank if not applicable.	□ Less than once a year	□ 2-3 times a year	□ 3-5 times a year	 More frequently than 5 times a year
Do you see any specialists for any diseases or chronic illnesses?	□ Yes, please list:			
How many medications do you take on a daily basis:	□ 0-2	□ 3-5	□ 5-7	□ More than 7
Do you use any social or community services to help you meet your healthcare needs?	□ Yes, please list:		12	

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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.

NEW PATIENT CHECKLIST

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

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Save

Complete