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
	___ Tia Fitzpatrick-Butler, NP	Glen Dust, MD
	___ Lauren Fore, MD / Cydney Longley, FNP	Brian Yocks, MD
	___ Alina Paul, MD	Lauren Coovert, PA-C
	___ David Liss, FNP	Tara Shutt, FNP-BC
Atwood	___ Danielle Pare, FNP	Andrea Tirpak, APN, FNP-BC
Cerro Gordo	___ Jamey Witmer, FNP	

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 _____

_____

KIRBY MEDICAL CENTER

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

Childhood illness: ❑ Measles ❑ Mumps ❑ Rubella ❑ Chickenpox ❑ Rheumatic Fever ❑ Polio

Immunizations and dates (if known):

❑ COVID
❑ Tetanus
❑ Hepatitis
❑ Influenza
❑ Pneumonia
❑ Chickenpox
❑ MMR *Measles, Mumps, Rubella*

Up to date with childhood vaccines? ❑ Yes ❑ No Why? _____

List any medical problems that other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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Have you ever had blood transfusion?	❑ Yes	❑ No

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

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, 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	❑ Medium	❑ Low	
Caffeine	❑ None	❑ Coffee	❑ Tea	❑ Cola	
	# of cups/cans per day?				
Dental Hygiene	❑ Been to dentist ❑ Date of Last Appointment: _____				

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	❑ M ❑ F	
Mother				❑ M ❑ F	
Sibling	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F		**Grandmother** *Maternal*		
	❑ M ❑ F		**Grandmother** *Paternal*		
	❑ M ❑ F		**Grandfather** *Maternal*		
	❑ M ❑ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	❑ Yes	❑ No
Do you feel depressed?	❑ Yes	❑ No
Do you panic when stressed?	❑ Yes	❑ No
Do you have problems with eating or your appetite?	❑ Yes	❑ No
Do you cry frequently?	❑ Yes	❑ No
Have you ever attempted suicide?	❑ Yes	❑ No
Have you seriously thought about hurting yourself?	❑ Yes	❑ No
Do you have trouble sleeping?	❑ Yes	❑ No
Have you ever been to a counselor?	❑ 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
	Have you considered stopping?	❑ Yes ❑ No
	Have you ever experienced blackouts?	❑ Yes ❑ No
	Are you prone to "binge" drinking?	❑ Yes ❑ Nc
	Do you drive after drinking?	❑ Yes ❑ No
Tobacco	Do you use tobacco?	❑ Yes ❑ No
	❑ Cigarettes - pks/day ❑ Chew - #/day ❑ Pipe - #/day	
	❑ # of years ❑ Or year quit ❑ Cigars - #/day	
Drugs	Do you currently use recreational or street drugs?	❑ Yes ❑ No
	Have you ever given yourself street drugs with a needle?	❑ Yes ❑ No
Sex	Are you sexually active?	❑ Yes ❑ Nc
	If yes, are you trying for a pregnancy?	❑ Yes ❑ No
	If not trying for a pregnancy, list contraceptive or barrier method used:	
	Any discomfort with intercourse?	❑ Yes ❑ 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?	❑ Yes ❑ No
Personal Safety	Do vou live alone?	❑ Yes ❑ No
	Do you have frequent falls?	❑ Yes ❑ No
	Do you have vision or hearing loss?	❑ Yes ❑ No
	Do you have an Advance Directive or Living Will?	❑ Yes ❑ No
	Would you like information on the preparation of these?	❑ Yes ❑ No
	Physical and/or mental abuse have 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?	❑ Yes ❑ No

WOMEN ONLY	
Date of onset of menstruation:	
Date of last menstruation:	
Period every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	❑ Yes ❑ No
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	❑ Yes ❑ No
Have you had a D&C, hysterectomy, or Cesarean?	❑ Yes ❑ No
Any urinary tract, bladder, or kidney infections within the last year?	❑ Yes ❑ No
Any blood in your urine?	❑ Yes ❑ No
Any problems with control of urination?	❑ Yes ❑ No
Any hot flashes or sweating at night?	❑ Yes ❑ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	❑ Yes ❑ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	❑ Yes ❑ 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?
If yes, # of times _____
Do you feel pain or burning with urination?
Any blood in your urine?
Do you feel burning during discharge from penis?
Has the force of your urination decreased?
Have you had any kidney, bladder, or prostate infections within the last 12 months?
Do you have any problems emptying your bladder completely?
Any difficulty with erection or ejaculation?
Any testicle pain or swelling?
Date of last prostate and rectal exam?
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.

❑ Skin	❑ Chest/Heart	❑ Recent changes in:
❑ Head/Neck	❑ Back	❑ Weight
❑ Ears	❑ Intestinal	❑ Energy Levels
❑ Nose	❑ Bladder	❑ Ability to sleep
❑ Throat	❑ Bowel	❑ Other pain/discomfort:
❑ Lungs	❑ Circulation	

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

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?	❑ 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? Leave blank if not applicable.	❑ Yes, please list:			

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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