

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 / Cydney Longley, FNP

\_\_\_ Crickett Engelbrecht, FNP-C \_\_\_ David Liss, FNP \_\_\_ Lauren Coovert, PA-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

PREFERRED METHOD OF CONTACT:

- |                               |                                  |
|-------------------------------|----------------------------------|
| <input type="checkbox"/> CALL | <input type="checkbox"/> EMAIL   |
| <input type="checkbox"/> TEXT | <input type="checkbox"/> 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 # \_\_\_\_\_ 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  
☐ E-mail Service Provided by ScanSTAT E-mail Address: \_\_\_\_\_ 217-762-1862

### 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

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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.

<b>Name (Last, First, M.I.):</b>		<b>DOB:</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

<b>Childhood illness:</b> <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		
<b>Immunizations and dates (if known):</b> <input type="checkbox"/> COVID	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
<b>Up to date with childhood vaccines?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Why? _____		
<b>List any medical problems that other doctors have diagnosed:</b>		

### Surgeries

Year	Reason	Hospital

### Other hospitalizations

Year	Reason	Hospital

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**KIRBYMEDICAL**  
CENTER

**NEW PATIENT INTAKE ADULT**

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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	
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise <input type="checkbox"/> Occasional vigorous exercise <input type="checkbox"/> Regular vigorous exercise
<b>Diet</b>	Are you on a special diet? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span> If yes, are you on a physician prescribed medical diet? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span> # 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 Rank sugar intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola # of cups/cans per day? _____
<b>Dental Hygiene</b>	<input type="checkbox"/> Been to dentist <input type="checkbox"/> Date of Last Appointment: _____

<b>Tobacco</b>	Secondhand smoke exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day

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

<b>MENTAL HEALTH</b>
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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



### 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.

\_\_\_\_\_  
Patient Signature

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.

\_\_\_\_\_  
Date

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Save

Complete

NEW PATIENT INTAKE ADULT

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