NEW PATIENT

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________________
Address One: ______________________ Social Security #: ______________________
Address Two: ______________________ Sex: __________ Primary Language: ______________
City: ______________________ Race: ______________ Ethnicity: ______________
State: ______________ Zip: __________ Usual Provider: ______________________
Landline Phone: ______________________ Referring Provider: ______________________
Work Phone: ______________________ Primary Provider: ______________________
Cell Phone: ______________________ Last HIPAA Sign: ______________________
Employer: ______________________ Email: ______________________
Designated phone for call reminder purposes: ______________

GUARANTOR/EMERGENCY INFORMATION

Name: ______________________ Date of Birth: ______________________
Address One: ______________________ Social Security #: ______________________
Address Two: ______________________ EMPLOYER: ______________________
City: ______________________
State: ______________ Zip: __________ EMERGENCY CONTACT: ______________________
Landline Phone: ______________________
Cell Phone: ______________________ EMERGENCY CONTACT PHONE: ______________________
Work Phone: ______________________

INSURANCE INFORMATION

Primary Insurance (Policy): ______________________ Secondary Insurance: ______________________
Certificate #: ______________________ Certificate # (Policy): ______________________
Group #: ______________________ Group #: ______________________
Group Name: ______________________ Group Name: ______________________
Subscriber Name: ______________________ Subscriber Name: ______________________
Subscriber DOB: ______________________ Subscriber DOB: ______________________
Subscriber SS#: ______________________ Subscriber SS#: ______________________

________ Authorization to Bill and Receive Payments: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits be made directly to my provider, when he/she accepts assignment. I have received the financial policy.

________ Acknowledgement of Receipt of Privacy Notice: I have received and reviewed a copies of the Notice of Privacy Practices and Financial Policy for the office of Northeast KS Facial Plastic, ENT and Pulmonology as of the date of my signature.

________ Email/Cell Authorization: Our doctors occasionally email other providers in coordination of you care. I am aware the email is not always secure and other parties may have access to this information. We/our representatives may also contact you via cellphone if that is the number you have provided us.

________ Authorization to Release Medical Information: I hereby authorize my provider or its representatives to discuss my information with the person(s) identified below. I also understand any change or revocation of this will need to be submitted in writing.

x ______________________________________ Date: ______________________

If there is anyone you would like to have access to your health/account information, please complete the information below:

______________________________________ ______________________
Address Phone Number

______________________________________ ______________________
Name of person authorized to recieve information Relationship

______________ Health information ______________ Billing information ______________ All information

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PATIENT HISTORY FORM

Pharmacy: ______________________

Please Fill in the Following as Completely as Possible

Name: ______________________ Date: ______________________

Date of Birth: ______________________ Referring Doctor: ______________________

SSN: ______________________ Is there any other doctor we should send your office note to? ☐ No ☐ Yes

Doctor Name: ______________________ Doctor Address: ______________________

Reason for Visit: ______________________

Meds

(list dose and frequency)

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Drug Allergies

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Smoke: ☐ No ☐ Quit ☐ Yes

Year quit if applicable ________ Packs/Day: ________

Drink: ☐ No ☐ Moderate ☐ Daily ☐ Occasionally

Other Tobacco: ______________________

Surgeries (with dates)

____

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____

If you are 64 and older, have you received a pneumonia vaccine? ☐ No ☐ Yes

Hove you received the flu shot **THIS** year? ☐ No ☐ Yes Date: ______________________

Health Maintenance: If you are a woman age 40-69, have you had a mammogram in the past two years? ☐ No ☐ Yes

If yes, please list date: ______________________

If you are age 50- 74, have you had a colonoscopy in the past 10 years, flexible sigmoidoscopy in the past five years or fecal occult blood test in the past year? ☐ No ☐ Yes If yes, please list date: ______________________

Please check if any of the following are YES

Immediate Family History

- ☐ Heart Disease
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Hearing Loss
- ☐ Anesthesia Problems
- ☐ Cancer

Health Questions for Patient

- ☐ Weight Loss/Gain
- ☐ Chills
- ☐ Fever
- ☐ Dizziness
- ☐ Night Sweats
- ☐ Cough
- ☐ Heartburn
- ☐ Nasal Obstruction
- ☐ Indigestion
- ☐ Bleeding Problems
- ☐ Normal Development
- ☐ Up-to-Date on shots
- ☐ Ringing in Ears
- ☐ Snoring
- ☐ Allergies
- ☐ Short of Breath
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Hearing Loss
- ☐ Joint/Muscle Pains
- ☐ Patient in Daycare

Patient Medical History

- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Attack
- ☐ Asthma
- ☐ Colorectal Cancer
- ☐ Breast Cancer
- ☐ Cancer other: ____________ ______________________
- ☐ COPD
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis

Other Medical Problems: ______________________