CHARLES W KENT, MD, INC

NEW PATIENT QUESTIONNAIRE

Patient Name: _____
Last Name First Name MI

Patient Demographics

Gender: □ Male □ Female **Marital Status:** □ Single □ Married □ Divorced □ Widowed

DOB: _____ /_____ /_____ **SSN:** _____ - ____ - _____

Address: _____
Mailing Address City State Zip

Home Phone No: (_____) _____ - _____ **Mobile Phone No:** (_____) _____ - _____

Work Phone No: (_____) _____ - _____ **Email Address:** _____

Messages

If unable to reach me:

□ You may leave a detailed message.

□ Please leave a message asking me to return your call.

□ Other (please specify)_____

Primary Insurance Company: _____

Name of Policy Holder: _____

Member ID: _____ **Group No:** _____

Secondary Insurance Company: _____

Name of Policy Holder: _____

Member ID: _____ **Group No:** _____

Emergency Contact: _____

Relationship: □ Spouse □ Parent □ Child □ Other (please specify)_____

Phone No: (_____) _____ - _____

How did you hear about our practice? _____

DIGITAL RECORDING: Digital records by handheld devices such as smartphones are prohibited on the premises in order to protect the privacy of other patients and staff in compliance with federal and state privacy laws.

FINANCIAL RESPONSIBILITY: All professional services are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with the office manager. Necessary forms will be completed to help expedite insurance carrier payments. However, you are responsible for all fees, regardless of insurance coverage. I have requested medical services from Charles W. Kent, M.D., Inc on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of appropriate statement.

ASSIGNMENT OF BENEFITS: I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Charles W. Kent, M.D., Inc for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize Charles W. Kent, M.D., Inc to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in course of examination or treatment and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Guardian Signature **Date**

HIPAA

Release of Information

□ My information is not to be released to anyone.

□ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Receipt of HIPAA Privacy Notice

At Dr. Kent's office, we are committed to maintaining the integrity of your protected health information as we comply with all applicable state and federal regulations. The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect as of April 14, 2003. In support of our policy of complying with all applicable regulations, we provide patients with the HIPAA Notice of Privacy Rights. While not required in order to receive treatment at this facility, we are obligated under federal regulations to ask that you sign an acknowledgment of the HIPAA Privacy Notice being made available to you.

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how my healthcare provider may use and disclose my protected health information. I understand that my healthcare provider reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Witness Signature **Date**

Medical History

Surgical History

□ I have had no prior surgery.

Date	Operation

Check conditions you currently have or have had in the past year

□ **No current conditions**

□ Anemia	□ Anxiety	□ Appendicitis	□ Arthritis
□ Asthma	□ High Blood Pressure	□ Low Blood Pressure	□ Cancer
□ Cataracts	□ Cardiac Stents	□ High Cholesterol	□ Depression
□ Diabetes	□ Epilepsy/Seizures	□ Glaucoma	□ Gout
□ Heart Attack	□ Heartburn/Reflux	□ Heart Disease	□ Hepatitis
□ Hernia	□ HIV Positive	□ Kidney Failure	□ Kidney Stones
□ Liver Disease	□ Lung Problems	□ Migraines	□ Neurological Problems
□ Osteoporosis	□ Pacemaker	□ Pneumonia	□ Psychiatric Care
□ Seasonal Allergies	□ Shortness of Breath	□ Sinus Problems	□ Stroke
□ Swollen Ankles	□ Spider/Varicose Veins	□ Thyroid Problems	□ Tuberculosis
□ Ulcers/Colitis			

□ Other (please specify) _____

_____

Allergies

□ I have no known allergies.

Name of Drug/Item	Reaction

Medications (Please include over-the-counter medications and vitamins/supplements.)

□ I am not currently on any medication

Name of Medication	Dosage	Times Per Day

Family History (check all that apply)

Illness	Mom	Dad	Child	Grandparent	Other Blood Relative (please specify)
Arthritis	□	□	□	□	□ _____
Asthma	□	□	□	□	□ _____
Cancer, Breast	□	□	□	□	□ _____
Cancer, Colon	□	□	□	□	□ _____
Cancer, Ovarian	□	-	□	□	□ _____
Cancer, Prostate	-	□	□	□	□ _____
Cancer, Skin	□	□	□	□	□ _____
Cancer, Other	□	□	□	□	□ _____
Depression	□	□	□	□	□ _____
Diabetes	□	□	□	□	□ _____
Glaucoma	□	□	□	□	□ _____
Heart Attack	□	□	□	□	□ _____
Heart Disease	□	□	□	□	□ _____
High Blood Pressure	□	□	□	□	□ _____
High Cholesterol	□	□	□	□	□ _____
Mental Illness	□	□	□	□	□ _____
Stroke	□	□	□	□	□ _____
Thyroid Disorders	□	□	□	□	□ _____
Varicose Veins	□	□	□	□	□ _____

Physical Activity

On average, how many days per week do you exercise for at least 20 minutes continuously?

□ 1-2 □ 3-4 □ 5 or more □ I do not exercise this much

Social History

Substance	Never	Previous (year quit)	Current (how often)
Tobacco	□	□ _____	□ _____
Recreational Drugs	□	□ _____	□ _____
Alcohol	□	□ _____	□ _____
Caffeine (soda/tea/coffee)	□	□ _____	□ _____

Review of Systems

□ No current symptoms

CONSTITUTIONAL SYMPTOMS:
□ Fever
□ Sudden weight loss or gain
□ Extreme fatigue

EYES:
□ Double vision
□ Blurred vision
□ Sudden loss of vision

EARS/NOSE/THROAT:
□ Ear pain
□ Decreased hearing
□ Runny nose
□ Sore throat

CARDIOVASCULAR:
□ Chest pain
□ Heart palpitations

RESPIRATORY:
□ Cough
□ Wheezing
□ Shortness of breath

GASTROINTESTINAL:
□ Loss of appetite
□ Nausea
□ Vomiting
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Blood in stools

GENITOURINARY:
□ Frequent daytime urination
□ Frequent nighttime urination
□ Painful urination
□ Urine leakage
□ Blood in urine
□ Irregular menses
□ Post-menopausal bleeding

SKIN:
□ Rash
□ Changing mole(s)
□ Change in hair or nails

MUSCULOSKELETAL:
□ Joint pain
□ Muscle weakness

NEUROLOGICAL:
□ Headache
□ Lightheadedness or dizziness
□ Numbness or tingling
□ Recent fall(s)
□ Memory loss

PSYCHIATRIC:
□ Depression
□ Anxiety
□ Suicidal thoughts

ENDOCRINE:
□ Excessive thirst
□ Heat or cold intolerance

HEMATOLOGIC:
□ Unusual bruising or bleeding
□ Enlarged lymph nodes