New Patient Questionnaire
Dr. Kristin van Konynenburg, M.D.
Whole Family Health Care of Longmont, PLLC

Date: _____ Phone #: _____

Name: _____ Email: _____

Address: _____ DOB: _____

Place of birth: _____

Emergency Contact Person and Phone # and Address: _____

_____

Insurance provider: _____

Guarantor: _____ Guarantor's DOB: _____

Group #: _____ ID #: _____

Claim address on card: _____

Employer: _____

Allergies (include all medication, environmental and food allergies/intolerances and what reaction you have to each substance):

_____

_____

Pharmacy: _____ Phone #: _____

Medications, vitamins, supplements and herbs (include dosage and frequency):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any health problems here:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had any of the following symptoms chronically or within the past six months (circle any that apply):

fatigue … lightheadedness … fever … chills … night sweats … blurry or double vision … headaches … neck pain … hearing loss … tinnitus … sore throat … runny nose … trouble swallowing … chest pain or pressure … shortness of breath … chronic cough … abdominal pain … acid reflux … constipation … diarrhea … black or bloody stool … joint pain … muscle pain … vertigo … tingling sensations … numbness … weakness … pelvic pain … pain with urination … urinary incontinence … frequent urination … trouble starting or stopping your stream … prostate problems … pain with sex and/or vaginal dryness … changes in hair or nails … depression … anxiety … mood swings

Further details or other symptoms:

_____

_____

_____

_____

_____

Please include all regular usage, including frequency and amount, both now and past use.
Tobacco: _____
Alcohol: _____
Marijuana: _____
Other drugs: _____

Exercise, including length of time and frequency: _____

Any dietary restrictions? _____
What did you have for breakfast? _____
Lunch (if last lunch yesterday, give yesterday's lunch)? _____
Dinner yesterday? _____

Are you: Married? _____ Partnered? _____ Single? _____
Are you sexually active? _____
Partners men, women, or both? _____

What kind of work do you do? _____
Do you enjoy your work? _____
Do you have a spiritual practice? _____ Religion? _____
Do you feel safe at home? _____
Has anyone ever hurt you at home? _____
What were the circumstances? _____

Family Medical History:

Mother: _____

Father: _____

Maternal grandfather: _____

Maternal grandmother: _____

Paternal grandfather: _____

Paternal grandmother: _____

Sisters/Brothers: _____

_____

Give the date of your last study, if you remember:

Colonoscopy: _____ Pneumonia shot: _____
Mammogram: _____ Flu shot: _____
Pap smear: _____ Hepatitis B series: _____
Stool blood test: _____ Hepatitis A series: _____
Tetanus shot: _____

Do you feel you have a purpose in life or a spiritual path? If so, what is it?

_____
_____
_____

What do you do for fun? _____

_____
_____

What are some of your health goals over the next year or two? _____

_____
_____
_____

(For women): Last menstrual period: _____ Postmenopausal? _____
Number of pregnancies: ___ Deliveries: ___ Living children: ___ Abortions: ___
Miscarriages: ___

Whole Family Health Care of Longmont, PLLC
Patient Agreement

Please initial each line and sign at the end of this form:

___ I authorize medical and health care treatment by Kristin van Konynenburg, M.D.

___ I understand that all refills, referrals and letters will be taken care of at the time of an appointment.

___ If I provide incorrect insurance information and a claim is rejected, I agree to a $30.00 fee for the extra time and expense of re-submitting my claim.

___ I agree to a $20.00 fee for any bounced checks.

___ I agree to a $20.00 fee per month for any unpaid bills that are past due over one month after I received a notice and/or invoice.

___ Cancellations or failure to show for an appointment with less than 24 hours notice will result in a $50.00 fee. Exceptions will be made for inclement weather or other situations that make it impossible to be present.

___ Dr. van Konynenburg notifies her patients about the results of all tests that are ordered, regardless of whether the findings are normal or abnormal. Occasionally, the results do not get sent to the office. If you have undergone routine medical testing and have not received the results within 14 business days, please call the office to ensure that the results of all completed tests are reported back to you.

___ I acknowledge that I have reviewed a copy of the Notice of Health Information Privacy Practices, and have taken a copy if desired (available on clipboard).

___ I authorize Dr. van Konynenburg to release my medical information to any physician or health care practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. This also extends to records regarding my child, if applicable.

___ Dr. van Konynenburg respects your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operations, or as specifically authorized by you.

___ I understand that I am responsible for all charges incurred for treatments rendered, even if my insurance company determines that any services are non-covered or excluded.

___ I understand that insurance reimbursement may not be available. My insurance company may not pay for office visits where the focus of the consultation is on wellness or herbal medicine, etc. Also, some of the lab tests that are ordered are kits sent to labs using innovative approaches to diagnostics and may not be reimbursed.

___ I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

___ I may revoke these authorizations in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

_____ _____

Patient signature Date
(or Guardian's signature, if patient is a minor)