

CHARLES W. KENT, MD, INC

Patient Sign-In Sheet

Patient Name: _____ DOB: ____/____/____

Address: _____

Primary Phone No: (____) _____ - _____

Secondary Phone No: (____) _____ - _____

Insurance: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND VALID ID

Reason for visit: physical medication refill sickness/injury
 diabetes blood pressure other _____

Any changes in your family medical history (parents, siblings, children)? No Yes
If yes, please explain: _____

Any current tobacco/nicotine use? No Yes
If yes, what type of tobacco/nicotine?
 cigarettes ____ pack/day cigars vape/e-cigarette chew/dip/snuff

Any current alcohol use? No Yes
If yes, how many drinks per week?
 10 or more drinks 6-9 drinks 2-5 drinks 1 drink or less per week.

Any current marijuana use? No Yes

On average, how many days per week do you exercise for at least 20 minutes continuously?
 I do not exercise this much 1-2 3-4 5 or more

Please rate your pain (circle your current pain level):
0 1 2 3 4 5 6 7 8 9 10
no pain mild moderate distressing severe unbearable - you request an ambulance

SYMPTOMS (please check CURRENT symptoms below):

- | | | |
|--|--|--|
| Constitutional symptoms:
<input type="checkbox"/> Fever
<input type="checkbox"/> Extreme fatigue | Gastrointestinal:
<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Blood in stools | Musculoskeletal:
<input type="checkbox"/> Pain located _____
<input type="checkbox"/> Muscle weakness |
| Eyes:
<input type="checkbox"/> Double vision
<input type="checkbox"/> Blurred vision | Genitourinary:
<input type="checkbox"/> Frequent daytime urination
<input type="checkbox"/> Frequent nighttime urination
<input type="checkbox"/> Painful urination
<input type="checkbox"/> Urine leakage
<input type="checkbox"/> Blood in urine | Neurological:
<input type="checkbox"/> Headache
<input type="checkbox"/> Lightheadedness or dizziness
<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Recent fall(s)
<input type="checkbox"/> Memory loss |
| Ears/Nose/Throat:
<input type="checkbox"/> Ear pain
<input type="checkbox"/> Decreased hearing
<input type="checkbox"/> Runny nose
<input type="checkbox"/> Sore throat | Skin:
<input type="checkbox"/> Rash
<input type="checkbox"/> Changing mole(s)
<input type="checkbox"/> Change in hair or nails | Psychiatric:
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Suicidal thoughts |
| Cardiovascular:
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Heart palpitations | | Endocrine:
<input type="checkbox"/> Excessive thirst |
| Respiratory:
<input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Shortness of breath | | Hematologic:
<input type="checkbox"/> Unusual bruising or bleeding
<input type="checkbox"/> Enlarged lymph nodes |

I understand that payment is due at time of service and agree to pay all charges in full. I authorize and direct my insurance carrier(s) to issue payment directly to Charles W Kent, MD, Inc. I have requested medical services from Charles W Kent, MD, Inc and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment. I understand that I am responsible for any amount not covered by my insurance. I authorize Charles W Kent, MD, Inc to: 1) release any information necessary to insurance carriers regarding my 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. Digital records are prohibited on the premises in order to protect the privacy of other patients and staff.

Patient/Guardian Signature _____ Date _____