

# Patient History Form

Date of Completion \_\_\_\_\_ Updated Date \_\_\_\_\_ Updated Date \_\_\_\_\_

## PATIENT INFORMATION:

Patient Name \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_  
Address \_\_\_\_\_ Marital Status: M S D W  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ PH# \_\_\_\_\_  
Birthplace \_\_\_\_\_ S.S #: \_\_\_\_\_ Cell# \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work# \_\_\_\_\_  
Are you responsible for this account? Y N If not, whom? \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ Ph# \_\_\_\_\_  
Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## INSURANCE INFORMATION:

Insurance Carrier \_\_\_\_\_  
Policy ID# \_\_\_\_\_ Group Name/Number \_\_\_\_\_  
Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ S.S \_\_\_\_\_  
Policy Holder Address \_\_\_\_\_ Sate \_\_\_\_\_ Zip Code \_\_\_\_\_  
Secondary Insurance? Y N Carrier \_\_\_\_\_ Policy Holder \_\_\_\_\_

## ADVANCED DIRECTIVES:

Have you ever completed a living will? Y N Have you ever completed a Power of Attorney for Health care Y N  
If you have completed these documents, please bring them to the office as soon as possible;

So we can make copies for our records.

If you have not completed Advanced Directives, would you like more information? Y N

Office use only: Packets given to patient and notified Dianne Geissal? Y N

## PATIENT HEALTH HISTORY:

Have you had a recent change in weight? Y N Gain of \_\_\_\_\_ lbs. Loss of \_\_\_\_\_ lbs.  
Date of last FLU shot \_\_\_\_\_ Date of Last PNEUMONIA shot \_\_\_\_\_  
Most recent Primary Care Physician \_\_\_\_\_ City/State \_\_\_\_\_

## ALLERGIES

Have you ever had hives, skin rash, breathing problems of allergic reactions to any medications? Y or N (please list)

Name of Med	Describe Allergic Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there any medications other than those you are allergic to, that you would prefer not to take due to prior unpleasant side-effects? Y or N (please list)

Have you had an allergic reaction to: (please circle)

Iodine or x-ray contrast dye? Y N

Latex or Rubber (glove, condom, balloons)? Y N

Dental Medical procedures, vaginal or rectal exam? Y N

Bee or wasp stings? Y N

Adhesive tape? Y N

List any food allergies \_\_\_\_\_

## CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- HAY FEVER
- ASTHMA
- MENINGITIS
- TUBERCULOSIS
- ARTHRITIS
- HEARING LOSS
- RHEUMATIC FEVER
- KIDNEY DISEASE
- ECZEMA/ PSORIASIS/ DERMATITIS
- OTHER: \_\_\_\_\_

- BLEEDING TENDENCY
- HEART DISEASE
- STOMACH ULCER
- HEPATITIS (JAUNDICE)
- ORGAN TRANSPLANT
- HIGH BLOOD PRESSURE
- STROKE / CVA
- MENTAL HEALTH DISORDER
- SEXUALLY TRANSMITTED DISEASE

- DIABETES
- EPILEPSY
- GLAUCOMA
- PNEUMONIA
- JOINT REPLACEMENT
- MEASLES (RUBELLA)
- CANCER
- NEUROLOGICAL DISORDER

DO YOU...				
SLEEP WELL?	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER
DRINK ALCOHOL?	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER
USE TOBACCO?	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER
DRINK CAFFEINE BEVERAGES?	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER
USE RECREATIONAL/STREET DRUGS?	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER
USE SEAT BELTS	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER
EXERCISE?	<input type="checkbox"/> FREQUENTLY	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> SELDOM	<input type="checkbox"/> NEVER

**HOSPITALIZATIONS:**

YEAR (most recent first)	Specify Illness/Surgery	Hospital Name, City & State

**INJURIES:**

YEAR (most recent first)	Type of Injury or Accident	Complication or Disability

CHECK IF **ANY** FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:

- |  |  |   |                                       |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> ALLERGIES         | <input type="checkbox"/> CANCER        | <input type="checkbox"/> HIGH BLOOD PRESSURE    | <input type="checkbox"/> BLINDNESS    |
| <input type="checkbox"/> ALCOHOLISM        | <input type="checkbox"/> DIABETES      | <input type="checkbox"/> KIDNEY DISEASE         | <input type="checkbox"/> HEARING LOSS |
| <input type="checkbox"/> ASTHMA            | <input type="checkbox"/> EPILEPSY      | <input type="checkbox"/> MENTAL HEALTH DISORDER | <input type="checkbox"/> STROKE, CVA  |
| <input type="checkbox"/> BLEEDING TENDENCY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> NEUROLOGICAL DISORDER  | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> OTHER _____       |  |   |                                       |

FAMILY MEMBER	Living OR Deceased	Major Illness and/or Cause of Death
FATHER	L D	
MOTHER	L D	
BROTHERS/SISTERS	L D	
M F	L D	
M F	L D	
M F	L D	
M F	L D	
M F	L D	
M F	L D	
SONS/DAUGHTERS	L D	
M F	L D	
M F	L D	
M F	L D	
M F	L D	
M F	L D	

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

Signature of person completing form (other than patient) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**CONSENT FOR TREATMENT**

I authorize and permit the staff of the Kirby Medical Center to employ such established treatment, therapy, or emergency care as may be deemed professionally necessary or advisable, including (1) diagnostic procedures, which may include blood tests for Hepatitis-B virus antigen and core antibody, ALT (liver function), HIV antibody (AIDS virus), RPR (Syphilis screen) and X-ray examinations, (2) surgical and medical treatment and, (3) blood transfusions. I permit the Emergency room doctors, my doctor, the Hospital and its employees, and all other persons caring for me to treat me in ways judged beneficial to me.

**DISCLOSURE STATEMENT**

You, the undersigned are about to sign a FINANCIAL AGREEMENT, obligating yourself to pay all Hospital charges.

Before you sign the FINANCIAL AGREEMENT, Kirby Medical Center is required by federal law to supply you with certain information. That information is as follows:

1. There will be NO (0) FINANCE CHARGE assessed and there will be NO (0) ANNUAL PERCENTAGE RATE as result of the terms of the FINANCIAL AGREEMENT.
2. If you fail to make one or more payments when due as specified in the FINANCIAL AGREEMENT, collection cost including court costs and reasonable attorney fees will be assessed against you.

**FINANCIAL AGREEMENT**

The undersigned agrees, whether he/she signs as agent, relative, or as patient, that in consideration of the services to be rendered to the patient, he/she will himself/herself pay the account of the Hospital for such services in accordance with its regular rates and terms. The undersigned further agrees that if this account becomes delinquent he/she will himself/herself pay all costs of collecting the same including court costs and reasonable attorney fees. No extensions of time or payment shall operate to release the undersigned from this obligation.

**ASSIGNMENT OF INSURANCE**

I hereby authorize payment directly to the Kirby Medical Center insurance benefits and authorize payment directly to the Hospital thereof but not to exceed the Hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the Hospital for charges not covered by this agreement.

**MEDICARE CERTIFICATION**

PATIENT'S CERTIFICATIONS "AUTHORIZATION TO RELEASE INFORMATION" AND PAYMENT REQUESTED. I certify that the information given by me in the applying for payment under the Title XVIII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**TEACHING FACILITY**

Kirby Medical Center is a teaching facility. I agree that medical students may be involved in my medical care.

**RELEASE OF INFORMATION**

I AUTHORIZE the Hospital to disclose all or any part of my hospital records to any person or corporation which is or may be liable under a contract to the Hospital or to me or to a family member or employer of mine for all or part of the Hospital's charge, including but not limited to hospital or medical service companies, insurance companies, Medicare, Medicaid, any other federal or state programs, worker's compensation carriers, welfare funds, my employer or any hospital or medical services utilization review program, organization or foundation acting for or in behalf or anyone of them. The Hospital is authorized to release copies of my records to my primary care physician and to all subsequent treatment providers, including but not limited to, home health services and nursing home care.

**ACKNOWLEDGE OF RECEIPT OF KIRBY MEDICAL CENTER'S HIPPA NOTICE OF PRIVACY PRACTICE**

I hereby acknowledge receipts of Kirby Medical Center Notice of Privacy Policies and understand that it explains when the Hospital may disclose my health information as well as my rights regards disclosure. I acknowledge that the Notice must be read for a full and proper understanding of Kirby Medical Center's privacy and disclosure policies and that I may contact the Hospital's Privacy Officer, for further explanation at 217-762-2115.

I hereby authorize, permit, certify, agree, and acknowledge as indicated above.

X \_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_  
Signature of person authorized to give consent for  
When patient is a minor, spouse or incompetent to give own consent

\_\_\_\_\_  
Signature of Witness

**PHI ACCESS FORM**  
**Family, Friends and Others Involved In Your Care**

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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By completing this form and signing below, you are granting Kirby Medical Center/ Kirby Medical Group permission to share protected health information (PHI), including without limitations, appointment information, test results, diagnosis, or treatment plans, with the individual(s) listed below who is/are family member, close friend, or other person involved in your care. Under certain medical circumstances, however, a licensed health care professional may identify one or more individuals after determining in his/her professional judgment that sharing PHI *on a continual basis* would be in the best interest of that patient (e.g. emergency situations, patient has Alzheimer's and no power of attorney was granted to caregiver, etc). There may be other medical situations where the Hospital may disclose PHI to family members of friends in accordance with federal or state law. Categories of people will not be accepted (e.g. "all family members" or "all members of your church") because of the difficulty in verifying their identity.

Name	Relationship	Address and Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

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If you have any questions and/or concerns related to completing this form, contact Medical Records at 217-762-1860

Verified identification Presented:     Illinois Drivers License     State ID     Other

\*\*\*\*\*PATIENT LABEL\*\*\*\*\*



# KIRBY MEDICAL GROUP

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## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name \_\_\_\_\_

Patient Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone \_\_\_\_\_ Med Record No. \_\_\_\_\_

1. I, the above named patient, hereby authorize:

\_\_\_\_\_ to disclose to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. The health information described below, which will be used for the purpose of \_\_\_\_\_

3. The health information to be disclosed covers the period(s) of health care:  
From (date) \_\_\_\_\_ to (date) \_\_\_\_\_ and  
From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Information to be disclosed (please describe):

\_\_\_\_\_ Complete health record(s) \_\_\_\_\_ Discharge Summary \_\_\_\_\_ History & Physical  
\_\_\_\_\_ Physician Progress Notes \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Emergency Department Record  
\_\_\_\_\_ Laboratory Tests (describe dates and types) \_\_\_\_\_ X-ray Reports (describe dates and types)  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_

Note: I understand that this will include information relating to (initial if applicable)

\_\_\_\_\_ Acquired immunodeficiency Syndrome (AIDS) or Human Immunodeficiency virus (HIV) Infection  
\_\_\_\_\_ Behavioral Health Services/Psychiatric Care \_\_\_\_\_ Treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at anytime, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following event condition, or 90 days from the date of authorization: \_\_\_\_\_.
5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in.
6. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signed: \_\_\_\_\_  
(Patient)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Or Legal Representative) (Relationship to Patient)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Witness)

Date: \_\_\_\_\_

Verified Identification Presented:

Illinois Drivers License

State ID

Other: \_\_\_\_\_

# of pages \_\_\_\_\_

Total Charge \_\_\_\_\_